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NOVEMBER-DECEMBER 1969

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Service Delivery and Social Action Through the Neighborhood Center

A Review of Research

Edward J. O'Donnell and Marilyn M. Sullivan

The star of the "income strategy" is ascending.[1] And it is high time. Poor people need money; ours is a money economy and "money talks." Poor people need power, too; they must organize and act. Some want to; a few will. People need money and people need power. Service is a poor substitute.[2] A "service strategy" is not at all fashionable; some say not at all relevant. Kravitz, for one, argues: "To talk about new forms of delivery of service... is to offer smelling salts when the patient is strangling, band-aids when the patient is bleeding to death... Building... new neighborhood centers amid slum squalor is immoral."[3] Perhaps so. But Specht reminds us of the "many needy people who may only want more and better service—who may not want to organize or protest, but simply to find alternatives to fighting City Hall and Bureaucracy."[4] The neighborhood service center holds promise of doing both—of providing better service and effecting social change. This article examines that promise.

The traditional organizations and institutions designed to provide services have, increasingly, come under fire. They have been swept along by social currents to the point of their being too big, too distant, and too self-serving. The traditional agency has been criticized as formal, fragmented, impersonal, officious, and timid; as alienating and intimidating people; as insuring long delays and expecting those it serves to accept its policy without question. But the neighborhood center has been championed as informal, integrated, personal, courteous, and courageous; as making people feel they belong; as offering instant service and promoting the active participation of the neighborhood in its program. Such, at any rate, is the rhetoric of the advocates of neighborhood centers.

The impetus behind it

The development of the neighborhood center owes much to a number of forces and movements—not the least significant of which has been the long-term migration of low-income Negroes and members of other minority groups to the cities, the out-migration of the more affluent white people to the suburbs, the increasing irrelevance of community agencies to the problems of poor people,[5] and the gradual decline of machine-dominated city politics. All but gone is the neighborhood ward "healer" and his patronage system for obtaining jobs, welfare, and legal advice for the poor.

The neighborhood center is an attempt to institutionalize many of the services performed by local political bosses. The neighborhood service system has become the functional equivalent of the old political ward system. The ward man has become the neighborhood worker; the political club, the neighborhood center. "People came to... [the ward man] to inquire about welfare payments, to get their relatives into public institutions, to get something done about neighborhood nuisances.... and to make complaints about the police or other city departments."[6] "He had to know his neighborhood thoroughly... catering to local interests and problems. He found jobs for needy families, or loaned them money.... For businessmen and saloon-

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keepers, he granted relief from some law or city ordinance; for gamblers, prostitutes, and gangsters in trouble, he found bail, or . . . he could arrange for the 'right' lawyer and the 'right' judge, who would arrange for the 'right' sentence."[7]

"If the ward leader was shrewd, he made his ward clubhouse into a pleasant place where a tired Manure Inspector or an Assistant Health Warden could find relaxation at the billiard table or at the bar where he could chew over the latest political gossip. If he was particularly canny, he would create a neighborhood esprit de corps . . . by having his club sponsor clambakes, picnics, summer outings . . . at least two 'balls' a year . . . torchlight parades and rallies. . . . Deeply political as it was . . . it served as a social institution as well. The clubhouse, like the saloon, was a haven for recreation and good fellowship, and a refuge from wives. And the club itself provided a means by which the native poor, or an immigrant Irishman or German, could advance to some social standing."[8]

Obviously, the comparison between the neighborhood service center and the old political club stops far short of many of the wardhealer's "services"; and though there are no more "tired" manure inspectors and neighborhood centers do not typically offer billiards and bars, the idea of a center's being a "pleasant place" and the effort to "create neighborhood esprit de corps" are not unalike. And though the center is no longer a "refuge from wives" (indeed, more likely a refuge from children), it can be "a haven for recreation and good fellowship." And, finally, though the "social standing and status" of "an immigrant Irishman or German" is no longer relevant, the advancement of the Appalachian, the Negro, the Puerto Rican, and the Mexican-American most certainly is. Just as the political club replaced the saloon as *the* grassroots center for neighborhood activity, so perhaps the neighborhood service center will eventually assume this role and responsibility.

But understanding the impetus behind the rise of the neighborhood center does not clarify all questions about its goals. These questions particularly stand out: Is the neighborhood service center primarily a means for making the best use of services by overcoming geographic and psychological distances? Can it successfully promote social action and institutional change? Is it merely a fact-gathering operation concerned with the identification of inadequacies in the welfare system and other traditional agencies? Can the center change services for the better? Can it provide better services itself? What is the best mix of service and action efforts?[9]

By examining some research evidence we can perhaps shed some light on these questions and raise still other issues.

Its organizational structure

Potentially, the settings of neighborhood service centers are as diversified as the programs they offer and the people they serve. "Such centers could be located in a variety of places, including public housing projects . . . settlement houses, neighborhood stores and shopping centers. They would be pleasant places to come to, open weekends and some evenings, with . . . overriding courtesy."[10] The continuing involvement of residents in the planning and staffing of programs is one of the center's innovations. Typically, area residents participate in center activities both as members of boards and committees and as staff workers. "Except for the very poor, the most militant, and the established political leadership, the boards represent a reasonable cross-section of the neighborhood."[11]

Neighborhood center staffs vary greatly in size—from one-man operations to those employing over a hundred. The median size of the 20 centers Perlman and Jones studied was 14;[12] a Brandeis University study of 54 centers found a median size staff of 15.[13] The proportion of workers from the neighborhood varies from center to center; however, virtually all try to employ some neighborhood people.

The neighborhood service center study by Kirschner Associates, and the studies of community action programs by Brandeis University and Hallman, indicate that more women than men were involved as staff employees and that, except in small towns and rural areas, more Negro than white women.[14]

Though the evidence on the employment of neighborhood workers indicates reasonable success, that on the participation of residents on boards and committees is less than compelling.[15] Kirschner Associates found that "the participation of the poor as employees . . . seems to be well advanced and largely successful. . . . Participation of the poor as policymakers and administrators seems to have been achieved on a quantitative basis but there appears to be little effective involvement due to a lack of training in some cases and a lack of authority in others."[16] Similarly, in reporting on the findings of a study of 12 community action programs, Clark writes that "the poor were involved as staff in all effective programs and as participants in voter registration drives, rent strikes and the like, but the degree of their participation was guided and to a large extent controlled by leaders not themselves poor. . . In no case of an

effective program were elected poor influential in major decisions, though several programs envisioned gradual involvement of neighborhood boards at policy-making levels."[17]

The services it offers

First and foremost, neighborhood service centers provide social services. Many combine services and social action, but all of them provide service in some form.

Kirschner Associates found wide variations in the kinds of services offered, ranging from centers concentrating on one service such as employment counseling to centers offering many different kinds of services to many different kinds of people. Almost all offered employment counseling and job placement services. Next came welfare, primarily through the aid to families with dependent children (AFDC) program. At least half provided educational and health services. Housing, recreational, consumer education, and legal aid services were offered in decreasing order with decreasing frequency.[18]

A study of neighborhood service programs undertaken by Abt Associates noted that "family life, welfare assistance, health, legal aid, and education programs" were generally offered to residents of the areas served.[19]

A sample of cases studied by Perlman and Jones at the Roxbury center in Boston found that the problems people presented, in order of frequency, were employment, legal, economic, housing, family, and health[20]—all consistent with services that centers generally make available.

Requisites for good service

Though the neighborhood service center has the obvious potential of being all things to all men, a reasonable list of requisites would include the following:[21]

Accessible. The center should be easy to get to. It should be open evenings and weekends and should provide emergency telephone service 24 hours a day.

Acceptable. The center should be clean, comfortable, and informal; its operation should be consistent with the neighborhood's way of life. Neither its employees nor its services should be foreign or alien. Faces should be familiar, and workers should be friendly and courteous.

Immediate. The center should provide prompt, efficient, immediate service. It should be able to respond to day-to-day problems without long hours of waiting and many rounds of appointments.

Comprehensive. The center should offer a full range of usable, on-the-spot services or easy access to other resources by available transportation. It should gear itself to the needs that people have—especially poor people—and provide for the simultaneous handling of problems where possible.

Integrated. The center should insure the coordination and integration of services so that they might be more effectively brought to bear on all the problems that people present.

Responsive. The center should reflect the needs and desires of the neighborhood. It should provide ways in which residents can shape the program and continue to contribute to its course and development. It should be relevant and ready to respond to changing needs.

These categories are neither mutually exclusive nor exhaustive. Several overlap. And though still others could be used, these seem to provide an analytically useful way to approach the literature.[22]

Research findings and performance criteria

These characteristics are criteria against which the achievements of the center can be measured. Together they are one basis for assessing centers and for organizing the findings of a variety of studies.[23]

Are centers accessible? Centers are located in low-income areas and, by virtue of their physical location, are at least more accessible than traditional agencies. Kirschner Associates note that the center is a way of introducing conventional community services to people for whom they have been previously unavailable.[24] Perlman and Jones report that, "in general, neighborhood centers serve people who live within walking distance or on transportation lines."[25] Data from their centers indicated that most clients were "walk-ins." In only one did the number referred from other agencies exceed that of those who came in on their own or who were referred by family, friends, or neighbors.[26] A number of centers have set up outreach operations. But some have had to cut back such efforts because of heavy demands on resources.[27] Most have found no shortage of persons to serve.

Nevertheless, the proportion of residents served varies greatly. Perlman and Jones' estimates suggest that their centers contacted from less than 2 percent of the area population of the Mobilization for Youth program in New York City to as many as 20 percent of the service population of Community Progress, Inc., in New Haven.[28] Based on figures from 10 of 20 sample centers, Kirschner Associates estimate that some 18 percent of the people in their neighborhood areas were reached.[29]

The number reached, however, may not reflect the actual number served. One neighborhood program, for example, contacted about 10,000 people but served fewer than 500.[30]

Great effort is going into reducing the psychological

distance between client and service unit by employing neighborhood people and making them visible and accessible in and out of the center. They typically provide outreach service and otherwise encourage agency-shy persons to use the center. Though it may be argued that centers are doing all they can to make their services accessible, it is clear that there are many more clients who need to be served and that clients will continue to overrun as many centers as are established.

Are services immediate? There is little evidence that centers as yet offer "instant" service. However, to the extent that they are at convenient locations, are open evenings and weekends, provide transportation, employ generalist receptionists and intake workers, have a range of on-the-spot services or access to such services through links to community agencies, the centers probably can rather promptly attend to client problems, particularly the day-to-day critical problems of poor people. Perlman and Jones describe the prospect for immediate service this way: "A receptionist, most often a woman who handled incoming calls and some clerical work, greeted the client, took her name and address, and arranged an appointment with one of the workers within a matter of minutes; rarely was there a wait of more than fifteen or twenty minutes. If an answer could be given... the receptionist would give the information; otherwise she would refer the client to another worker."[31] "In Roxbury, 74% of the clients were seen immediately by one of the services, 14% were seen by appointment, and 12% were not recorded."[32]

Centers are usually inundated with demands on their scarce resources and find themselves having to make the same hard choices as traditional agencies. Perlman and Jones note that "going beyond" instant service "requires the investment of a substantial amount of staff time with clients who require intensive and extended service" and raise this issue: "Should quick service to ten clients take precedence over intensive service to one?"[33] Given the great demand and the relatively few resources at their disposal, their centers soon responded in either of two ways. They continued to do what they could to serve individual clients and families by stretching or expanding resources and by cutting back on client recruitment, or they played down individual services and organized neighborhood groups to demand more and better services from other agencies.[34]

The second recourse--community action--becomes problematic, however, when the client's perception of the neighborhood center is taken into account. "In their view the purpose of the center is to help people by providing them with the services they need ... the idea of organizing the poor to help themselves is not very prominent in the client's perceptions."[35]

The question of whether neighborhood centers have the ability to respond promptly to resident needs remains open. They may be able to serve a few and to cut redtape for a few others but for the rest--a prompt reception may stop far short of much-needed service. A client cutback is no solution. Is an invitation to "come, let us organize together" any better?

Are services acceptable? Services should be in keeping with neighborhood life styles. Perlman and Jones observed an "easy and friendly atmosphere" in the centers they visited,[36] and Kirschner Associates refer to the "modest size and relatively simple organization" of most of their sample centers. "There is every indication that people ... found them warm and welcoming."[37]

Though most centers have the kind of casual and informal atmosphere that appeals to poor people, Kirschner Associates observed that in some cities, the very large centers have assumed an unattractive institutional quality.[38] Abt Associates found that in nine of the 13 programs they studied, core service facilities were inadequate due to cramped space and lack of privacy. Large meeting rooms within the center itself were not generally available but were provided by schools and churches; in any event, poor facilities apparently had not hindered program effectiveness.[39] Generally, the facilities available for neighborhood centers have been more or less adequate and relatively acceptable to residents.

As we have indicated, the presence in the program of workers from the neighborhood, people with whom the residents can readily identify, also makes the center more acceptable. In commenting on the phenomenon that a few residents came from considerable distances to the center, Perlman and Jones allude to psychological proximity. "Some find the centers less formidable than large, impersonal offices of agencies that may actually be closer to them; some Negroes or Puerto Ricans feel more at home in an agency where they find people of their own ethnic group on the staff."[40] In the Kirschner Associates study, the characteristics of both the people served and the center staffs were similar. In fact, the only differences between the two were that the residents had larger families and the staffs more education.[41] The characteristics of the nonprofessional staff members of the community action program reported in the Brandeis study were also similar.[42] To the extent that such similar characteristics contribute to the client's ability to identify with workers and feel more "at home," neigh-

borhood centers seem to be acceptable to the people served.

Are services comprehensive? One sign of a comprehensive center is the variety of its programs and activities. The 54 centers in the Brandeis study offered from four to 10 services. Half were locally developed, direct services, 25 percent were "national emphasis" and other programs, and the rest were neighborhood organization and self-help activities.[43] The specific services most often provided focused on health, recreation, counseling, employment, and education; the economic programs on buyers' clubs and tenant unions; and the special projects on neighborhood clean-up campaigns and voter registration drives. Four of every five centers promoted these programs and projects,[44] and most provided some combination. The neighborhood service programs reported on by Abt Associates were heavily weighed toward service. Few programs had developed community action to the point where neighborhoods were able to manage their own affairs and develop their own areas.[45] Among the component programs of the neighborhood service programs, about 60 percent emphasized social service; some 35 percent "opportunity enhancement;" and 10 percent community mobilization.[46]

Kirschner Associates found a very broad range of social services in their centers. Though programs in the smaller communities and rural areas were more diversified, most provided several different services. A highly specialized center was unusual.[47] The method of providing service varied greatly—from information and referral to on-the-spot service. "The bulk of their service functions involve . . . traditional services . . . very few . . . are 'new inventions'."[48] What is novel is the neighborhood package of public and private services.

In examining the extent to which center services approach comprehensiveness, the relative mix of services becomes crucial. Kirschner Associates' findings are relevant here: 60 percent of their centers offered employment and welfare services *or* employment and health services, and 40 percent linked four services together—education, employment, welfare, and health.[49]

But the fact that centers offer a range of services does little to insure their use. In fact, data from the Roxbury center raise serious questions about the comprehensiveness of service—from the client's view. The service outcome of a 15 percent sample of clients served in 1965 was as follows: of 92 cases presented at intake, 36 were referred to social service, 33 to employment, and 19 to the legal unit. The receptionist handled one case; the fate of three others is not clear. Of those referred fully 69 had contact with one unit only. Of the 23 recipients who had subsequent contact with another unit, 16 had direct contact with two and seven with three.[50] Thus, it appears that fewer than three of 10 clients were able to use more than one service. The Roxbury data seem consistent with those of the Kirschner Associates study, which found that clients are oriented to a single service and "often do not even know that it is a neighborhood service center as such."[51]

If the neighborhood center merely provides increased accessibility to selected services, it is possible that single-service agencies decentralized into a neighborhood center would accomplish the same purpose. At any rate, the case for comprehensive, one-stop service in the neighborhood center is less than persuasive. It is not enough for services to be accessible, even immediately available, if they cannot meet the different needs that people have. Moreover, they are only potentially comprehensive unless the different services can be effectively coordinated and made meaningful and usable.

Are services integrated? Proximity of itself may facilitate but cannot insure coordinated services,[52] a point Perlman and Jones make about the presence of staff representatives of other agencies in neighborhood centers, holds for center staffs, too. Abt Associates note that, though core service activity was relatively successful in coordinating the movement of clients through the system of the neighborhood service programs, in four the core service unit was separate from other service units and that this separation contributed greatly to service fragmentation and lack of coordination.[53] Even where staff members are present together, problems of communication and coordination exist and are exacerbated when the center director has no effective administrative control over workers from other agencies. In eight of the 13 neighborhood service programs, the directors had no control over other agency workers.[54] When center workers are responsible to other agencies, problems in communication and effective service coordination are more likely to occur. But, just as physical proximity does not guarantee integrated services, neither does administrative control.

Perlman and Jones found that, in the Roxbury center, "barriers to interdisciplinary cooperation were serious within . . . core staff . . . under the same administration."[55] Such a problem is fairly widespread. The Kirschner Associates study suggests that linked services do not automatically insure coordination. They found little evidence of "carefully planned efforts to present well coordinated service programs. This is something

often talked about but rarely achieved."[56] Abt Associates also found that the integration and coordination of services was a major problem.[57] Few formal coordinating mechanisms had been set up, and workers mostly relied on informal relations and communications.[58] Kirschner Associates found some successful "case" coordination, but at a cost of considerable time and effort.[59] Perlman and Jones note that "commitment to the goals of marshalling resources for the benefit of clients seems to be most crucial in these arrangements" and that such commitment must be shared by both agency and worker.[60] Though centers have devised some means for coordination—the rotation of intake, the anchor worker, the case conference, the central file system, the case coordinator—none of them have been wholly effective.

As pointed out, most center contacts are with one service only. Of the 23 cases provided with two or more services in the Roxbury sample, only four were the subject of a "review conference." The service coordinator was often pressed into providing direct service and could not spend enough time in interservice coordination.[61] Abt Associates found a similar situation.[62] The Roxbury center concentrated multiservice activity on proportionately few cases. In one month's period, 5 percent of the recipients had 30 percent of the contacts.[63] Thus, even when multiservice activity takes place, only a few recipients can be served. It is clear that neighborhood centers suffer from some of the traditional problems of specialization and fragmentation. Just as different agencies strive to maintain autonomy and independence, so do different center services. Organizational sovereignity and professional ideology both contribute to this condition, as does the need for organizational survival and professional status. "Each service tends to perceive problems in its own terms and is reluctant to 'surrender' its clients or share them with another service."[64] Because services are "different," they are likely to draw on different resources, use different people, perform different functions, and serve different needs in different groups of people.

In the Kirschner Associates centers, though education and employment services were linked in some 60 percent of the centers, there was no evidence of their coordination. "To the contrary, the two services deal with different clientele."[65]

The attempt to coordinate and rationalize services is at many levels: within the center's service units, between the center and participating agencies, and between the center and all other agencies serving the neighborhood. As one of their tasks, centers try to coordinate and improve community services. The Brandeis study found, in fact, that some 14 percent of their centers saw coordination as a primary objective—taking precedence over the provision of direct service, community organization, and case finding and referral.[66] Kirschner Associates found, however, little marked success in this regard.[67] Because few centers provide "new" services, they are left trying to use, coordinate, and improve traditional community services. The Abt Associates study reports that, at first, residents in many communities did not want to work with traditional agencies, which had neglected them for years, and were reluctant to share their few resources with the community.[68] The strain between neighborhood centers and community agencies is an obvious obstacle to effective coordination.

But still other functions of the center may also block the coordination of services: "Some centers concentrate on developing an informal atmosphere that is inviting to the poor people of the neighborhood. These centers are less concerned with service integration or refinements. Other centers encourage attitudes and organizational arrangements associated with aggressive community action and these appear antithetical to close collaboration with traditional agencies."[69] Either stance militates against effective integration. Coordination of services remains an elusive objective, if not the major challenge.

Are services responsive? One way to judge the responsiveness of centers to neighborhood needs is to look at the response of the residents to the centers. Such response has far exceeded expectations.[70] Moreover, the services provided seem to be more or less consistent with the problems. Abt Associates report that residents were generally consulted about their most pressing problems and that these problems were those the programs attempted to handle.[71] Though some centers have shifted programs to meet resident needs and demands, others have done so for want of funds and resources. In all neighborhood service programs, activity has been limited by lack of money, staff, and proficiency. They have not been fully responsive to resident needs for employment, job training, and housing. But, in general, they "have addressed themselves to the most salient needs of the community, where they had the resources to do so."[72]

Perlman and Jones report that their centers apparently served people who both racially and ethnically represented the neighborhood. Moreover, by and large, these centers attracted the kinds of people who could best be helped, given the kinds of service offered.[73]

Though few centers are set up for formal, systematic

review and followup, recipients can take part in center programs and policymaking in several ways—principally through board, committee, staff, and volunteer work. Abt Associates found an overriding desire in residents for a larger voice in neighborhood service programs. But, of 13 programs, "only in five of the cities have the residents really had a voice in setting policy."[74] Here the staff positions open to neighborhood people promised rapid advancement and opportunity to effect key decisions; participation on boards, committees, and neighborhood corporations was rewarding and residents could influence program activities.[75] The opportunity for rewarding involvement in the other eight centers, however, apparently left much to be desired. As we have seen, the evidence for effective resident participation on center boards and committees is hardly persuasive; the obstacles are many and hard to overcome; and, though there is reason for optimism about participation by neighborhood workers, the limits of their role circumscribe their contribution.

To the extent that the center's responsiveness is assessed by the opportunity neighborhood people have for shaping policies and programs, most centers could be much more "responsive." But to the extent that centers have moved at all to facilitate resident expression and to make programs accessible and acceptable, they have made a beginning.

But are they effective? Assuming that services are accessible and acceptable—which they are—and assuming that they are responsive and comprehensive—which they may well be—and even assuming that they are immediately available and well integrated—which they are not—the question remains: Are they effective?

The evidence for the effectiveness of neighborhood centers is based at this point on gross impressions and guesswork. Until data are available on the ways in which centers help solve the problems people have or strengthen their capacity for dealing with them and until we learn whether and how centers improve the quality of neighborhood life and influence community agencies and institutions, there is really little to say. Nevertheless, we can review and summarize the prevailing impressions.

Abt Associates report that in most of the cities they studied, programs have been reasonably effective. In the few cities where they have not been, the neighborhood service program "has proved to be yet another program that promises many benefits and produces few results."[76]

In general these centers have provided an impressive array of services and, though quality varies greatly, service is now available, and all within a short time.[77] Specifically, eight of the neighborhood programs had improved neighborhood services and had begun to meet resident needs. They had introduced new resources and had begun to coordinate and integrate others. Traditional agencies had become more responsive and were modifying hiring policies to the advantage of poor people. These centers have gained the confidence of the people they serve and have demonstrated that neighborhood people can develop and operate their own programs.[78]

Kirschner Associates interviewed some 189 clients and neighborhood residents. The responses of those interviewed to two questions are especially pertinent in assessing how helpful the centers were. When asked what the centers had done for them and their families, three out of 10 said "nothing." Though 70 percent mentioned receiving one or another service, the fact that nearly a third of those presumably served replied "nothing" rules out any great enthusiasm for the centers.[79] Yet a question tapping whether residents felt better off because of the center yielded less equivocal findings. Some 60 percent of the respondents in medium-sized and large cities and fully 95 percent in small towns and rural areas felt "much better off" because of the centers.[80] These centers were mostly service oriented and were, by virtue of their small size, less forbidding than large, bureaucratic urban organizations.[81]

In summing up, Kirschner Associates say that neighborhood centers have undoubtedly contributed to change: several public and private agencies have become more flexible and have modified practices to make them more relevant; political institutions have become more alert and, in some instances, more sensitive. But economic institutions and the neighborhood environment appear to be little affected. The poor people employed by the centers appear to have changed the most, and many seem to have acquired confidence and a sense of having made worthwhile contributions. Some board members share this enthusiasm, but others are disillusioned. Of the persons served in general, they note "that most have not yet been reached in a meaningful way at all; that some have become clients for services and perceive the centers as givers of services and themselves as recipients of services; and that a still smaller number regard themselves as active members of society with the right and ability to influence it. To the extent that these feelings represent shifts from apathetic, helpless attitudes they are significant and appear to relate to some involvement with the center."[82]

Perlman and Jones found that neighborhood centers were able to identify pressing needs and were moving toward meeting them. They also observed that centers were instrumental in stimulating traditional service agencies to change and had found rather creative ways to make full use of their scarce resources.[83] Given their relative youthfulness and the many constraints under which they function, even small successes are impressive.

Social action

Neighborhood service centers always include a service component–it is their reason for being. However, the "package deal" offered may or may not include a social action component. Implicit in describing social action efforts in centers are these questions: What type of social action can be promoted? and What is its relative weight in the program? Data from the Brandeis study indicate that, though community organization projects absorbed only about 25 percent of the center's activities, 43 percent of the centers saw the organization of residents as their primary objective.[84]

Social action is difficult to define; its methods may run from complete cooperation with other groups to all-out conflict. "Social action . . . means and demands the stimulation of concern among individuals who share a common predicament; who are victims of long standing community problems and injustices, who can be induced not only to identify their problems but to seek to determine the methods by which they can be resolved, and who are able to develop and sustain the initiative for the type of collective action, which, in fact, does resolve or ameliorate these problems."[85]

Perlman and Jones explicate four goals for social action: delivering social services more effectively; fostering concrete self-help efforts; providing for the poor the social and psychological benefits of taking part in organizational life; and changing policies and practices among relevant agencies and institutions.[86]

The Kirschner Associates study found no clear evidence of the effectiveness of social action. Attempts were made to develop new service programs and activities such as tutoring programs, day-care centers, thrift shops, and recreation programs. And half of their centers had conducted cleanup campaigns, but these were invariably started by community action officials. "This type of community action is not a spontaneous thing for poverty area residents. Rather it is a middle-class concern. . ."[87]

Clark suggests "that the threshold of tolerability for significant changes in the predicament of the poor is rather low for politicians and may be somewhat higher but not particularly high for middle-class professionals and even those staff members who are charged with the responsibility for directing community action and other programs in behalf of the poor. . . . This . . . tends to result either in the maintenance of the status quo or in the restriction of community action programs to techniques and methods acceptable to the middle class, thereby limiting the rate or the amount of change permitted the poor."[88]

The problems inherent in the development of citizen organizations are how to stimulate and how to sustain interest. Research shows that poor people are physical, visual, problem-centered, and action-oriented rather than verbal. Committee meetings, written reports, and abstract discussions may not accomplish specific goals.[89]

Perlman and Jones, say: "Neighborhood groups find it difficult to move from a situation of shared individual interests to a common concern for larger social issues."[90] Bread-and-butter issues are necessary. Unless there are immediate rewards, rank-and-file participants quickly lose interest.

Abt Associates found less resident interest in community mobilization than in some of the more concrete social services, and few of their centers tried to foster community organization.[91]

Organizing for more effective delivery of social services and stimulating self-help are directed toward amelioration and not change. For this reason, residents may see such goals as demeaning and palliative and as "put-offs." Nevertheless, they can offer invaluable educational benefits and a point of departure for residents.

Another rationale for social action is the social and psychological benefits derived from participating in organizational life. Ideally, participation in collective social action may "reduce alienation and anomie; provide opportunities for self-fulfillment; overcome feelings of powerlessness; improve the individual and group self-image of those who participate; and generally increase community integration and control."[93] But we have little evidence to suggest that it does all or any of these.

Institutional change is usually only a small aspect of a center's program. We have little data on the success of efforts in this direction. Wharf's recent study of the Roxbury Multi-Service Center found that the center had minimal effect on its "target agencies" and could not achieve significant organizational change.[94] This objective is sometimes directed at other than service institutions and is often put into operation with conflict-

oriented social action methods. Here, the keys are money and power; the kinds of technique range from nonviolent protest marches and economic boycott of merchants and public transportation to more violent demonstrations such as "sit-ins," work stoppages, and riots. Explicit goals are usually "against" rather than "for" something–mobilizing voter registration to defeat a racist candidate, for instance.

Perlman and Jones identify two central issues in promoting social action:

- The centers cannot create and hope to control autonomous and independent groups.
- The groups may threaten the sponsor or other relevant reference groups in the community.[95]

Such problems inhibit the widespread development of neighborhood and community action efforts.

Is it any wonder that few if any neighborhood service centers engage in conflict-oriented social action? Hallman says: "Except for a very small number of communities, the Community Action Program does not involve a predominant commitment to the strategy of giving power to the poor, of deliberate confrontation with established power, of purposefully created conflict."[96]

Similarly, Kirschner Associates found conflict-oriented social action against the political power structure in few of the rural centers and in only about 25 percent of the urban centers partly because of the relationship to the sponsor.[97] Marris and Rein, in commenting on this dilemma, say: "If the sponsors cannot disdain responsibility for the organization they create, and if... they defeat their own purpose in seeking to control it, only a sponsor free from other commitments can afford to support his organization in whatever course it chooses.... It is not unlikely that participants who are encouraged to take action... may challenge the sponsor's basis of allocating resources; and the 'citizens' organization may want to utilize tactics and develop strategies which the sponsor may find incompatible with its own principles."[98]

Realize, though, that the question of what type of social action to be implemented is not merely a this-or-that position; even highly cooperative community development efforts can have undesirable consequences for the center. Clearly, however, conflict-oriented social action methods are not usually followed under the guise of the neighborhood service center, and collaborative and cooperative efforts for change only operate successfully within a defined sphere of influence. Cohen suggests: "I think of these service type operations as a range within which there can be certain levels of social action, but I don't think it is a mechanism through which we can get at the larger question."[99]

Thus, the social action component in the neighborhood service center tends to be a self-help, community development effort based on cooperation and collaboration and the use of mild protest and peaceful demonstration only in certain circumscribed situations to obtain immediate and concrete goals.

Services or action?

What exactly is at issue in weighing social services against social action?

Rainwater says: "In the services business it is easy to forget about... the things that people need and want that aren't provided by services.... The minute you adopt a service strategy... for dealing with the problem of poverty... you're setting priorities for the families involved.... Poor people would rather make these decisions themselves."[100] Social service and social action programs often aim at different goals: the first at having "the professional" decide what the poor person needs and administering the right measure; the second at giving the poor enough power and leverage to decide and to act to get what they want and need.

Overlying both goals are the organizational problems raised by a neighborhood service center. The limitation of resources, both of staff time and program funds, almost intrinsically demands a choice of service or action as the major program goal. All too often "agencies try to cover too much ground;... they are good neither in service nor in ... social action."[101]

Perlman and Jones found that in five programs they studied, three deemphasized social services and stressed community organization. The others continued to emphasize services but had to cut back programs by either stretching resources or providing special services or closing intake at several points until the caseload became manageable.[102]

Grosser, in a study of community organization in six youth programs, found that "social action and service components may exist either as part of a comprehensive project, or more desirably, as separate cooperative entities. The separation of the services and action functions into discrete organizations is suggested because the two functions are frequently in disharmony... and because the dispensers of public agency services are congenitally and organizationally unable to distinguish between the protest and service function when practiced by the same organization."[103]

Findings from the Brandeis study further suggest

"that it is not possible to give equal attention to both of the objectives... in a single unit and that most frequently service delivery requirements take precedence over... action."[104] Kirschner Associates make a similar point: "The evidence indicates that it is extremely rare to find both aggressive community action and well executed service programs within the same center."[105]

Perlman and Jones further suggest that the form of the services-action relationship in a center depends both on the activities involved in each and on what the community is willing to accept.[106] To ease tension between the two, they suggest that a center become primarily an instrument of social action, that its services act only to attract participants and to help them with their problems.

The Kirschner Associates study supports the method of attracting the poor to the center with the offer of services. They found that "the idea of community action in which the poor organize to deal with their problems themselves is not very prominent in their thoughts about the neighborhood centers. The poor, however, do understand the idea of services."[107]

Combining services and action in one center, as we have seen, is not without its problems, however, because of the difficulty of coordinating center programs and those of other community agencies. The autonomy of the center, its interest in community action, and the participation of residents are, as noted, key influences contributing to lack of service coordination between the neighborhood center and the "downtown" agency.

Hallman reminds us, however, that the "variation found among the communities does not reflect a choice between services and citizen organization. Those who follow the most activist approach to resident participation also provide services, and many but not all of those with effective service programs pursue certain forms of resident participation. The crucial difference is the approach to institutional change and to planning and coordination."[108]

Although Hallman is undoubtedly correct in suggesting that a broad overlap exists between services and action and in specifying that the choice in the world of the neighborhood service center is usually one of method rather than policy, nevertheless, methods do ultimately contribute to program emphasis and action.

Thus, the durable services-action issue is one that each center must inevitably confront.

Issues without answers

In this section we will attempt to indicate some of the more salient issues to be confronted–if not completely resolved. The main issues revolve around questions of organizational sponsorship; the specification of goals; the kinds of interventions developed; the types of workers employed; and the implications of any or all of these for the survival and success of the neighborhood center. Though some of these questions can be cast as either-or-dilemmas, it is not necessary that one preclude the other. In fact, both will be present in some form; it is a question of relative emphasis and of possible trade-offs between the two. These options are, of course, unduly simplified, even arbitrary, not necessarily contradictory, certainly not exhaustive, and in many ways artificial.

A center may emphasize professional direction and administration *or* resident participation and neighborhood control. If *administration*, programs and services may be run more smoothly and efficiently–but may not be entirely relevant to the needs and desires of residents; if *participation*, the center may be more responsive to neighborhood wants–but lack the administrative sophistication and organizational skill to operate effective programs.

A center may emphasize the provision of service *or* social action. If *service*, individual needs may be better satisfied–but some of the larger community issues may be neglected; if *action*, collective needs may be fully addressed–but the particular problems that people have may not be solved.

A center may emphasize special functions *or* general activities. If *special*, unusual and particular functions may be carried out with dispatch–but the effective integration of activities will be weak; if *general*, the center may be better coordinated–but no one aspect will receive the kind of attention required to make a real contribution.

A center may emphasize professional service *or* nonprofessional services. If *professional*, a relatively few clients may be competently served–but many potential clients may not be reached; if *nonprofessional*, many more neighborhood residents will be attracted to the center–but deeply personal problems will not be presented and complicated problems may not be adequately handled.

A center may emphasize information and referral *or* client advocacy and followup. If *information*, existing agencies may become more widely known and used–but questions of service modification and agency practice will not be sufficiently dealt with; if *advocacy*, traditional services may be challenged and different patterns of relationships hammered out–but fewer clients may be actually served and other problems may be created in the process.

A center may emphasize collaborative and cooperative methods *or* contest and conflict tactics. If *cooperative*, the good will and resources of other agencies and institutions may be more readily available–but the center may become preoccupied with the process to the neglect of hard results; if *conflict*, the center may be able to force some issues and achieve some action–but may have to go it alone and run the risk of diminishing resources and community support.

A center may emphasize neighborhood development and resident self-help *or* community change and political action. If *development,* residents may gain a sense of satisfaction, pride, and confidence—but the broader institutions that impinge on the neighborhood may remain untouched; if *change,* important political issues may be confronted—but the immediate effect on the neighborhood and its residents may be less than obvious.

A center may emphasize the problems and prospects of one particular group or institution *or* many different groups or institutions. If *one,* the group or institution may become better known and more surely helped or influenced—but others may remain unaffected if not disaffected by the center's work; if *many,* a number of different groups or institutions may be touched but perhaps no one in particular will become sufficiently well identified and changed by the center.

Again, these alternatives are not so much choices to be made as they are chances to be taken and risks to be run. In practice, both may be pursued simultaneously; indeed, the pursuit of one may lead to the other. But, at some point, the fact that they often require different resources, point in different directions, and have different costs and consequences may mean, to the extent these alternatives are attempted in the same center, that one or the other emphasis will eventually be given primacy.

In describing the experience of one of the early neighborhood service centers sponsored by Mobilization for Youth, Cloward and Elman sum up their impression this way: "The storefront on Stanton Street has been in existence a little less than four years and its work has increased tenfold . . . . It is still too early to evaluate its permanent contributions to life in the community. Its powers have been limited. It has not yet been able to change substantially the terms of economic dependency when it still seems to be the consensus among most legislators and their constituents that such dependency is to be discouraged, abhored, and punished. Many more people from Stanton street are on welfare than before. The storefront's clients are better clothed, better housed, and better fed than they were four years ago. Many now have telephones, quite a few have washing machines and television sets. Are they better people? Are they worse? Such questions seem like the supreme irrelevancy. For if they are not better for their improved economic circumstances, the society is better for their actions against it." And so it is.

This is the bottom line: the extent to which we help people is the ultimate test. We must ask—as a result of the center—are people better off? And we must, sooner or later, be able to answer—yes—or stand to abandon the idea.

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[1] *President Nixon's proposed family assistance plan is one indication of this, as is the interest in the negative income tax, children's allowances, and the income supplementation plan of the President's Commission on Income Maintenance Programs. See* Poverty Amid Plenty: The American Paradox, *Report of the President's Commission on Income Maintenance Programs, Nov. 12, 1969.*

[2] *See* Special Report: Sick Cities—and the Search for a Cure, *especially Daniel P. Moynihan, "The Urban Negro Is the 'Urban Problem'," pp. 36-38, and Lee Rainwater, "The Services Strategy vs. the Income Strategy, pp. 40-41,* Trans-action, *Oct. 1967.*

[3] *Sanford Kravitz, "Issues and Opportunities Facing Public Welfare,"* Public Welfare, *vol. XXVI, No. 1, Jan. 1968, pp. 5-6.*

[4] *Harry Specht, "Community Development in Low-Income Negro Areas,"* Social Work, *Oct. 1966, p. 78. It is interesting to note that the Heineman Commission sees the neighborhood center as a worthy vehicle for service delivery at the local level: "We recommend that the basic services provided through Federally-aided programs be included in multi-purpose urban neighborhood service centers which would provide a single location from which social services could be dispensed. These neighborhood service centers also could provide information and referral services, have outlets for manpower programs, and provide space for clinical services." See* Poverty Amid Plenty: The American Paradox, *p. 162.*

[5] *See, for example, Albert Rose, "The Social Services in the Modern Metropolis,"* Social Service Review, *Dec. 1963, pp. 375-389.*

[6] *Edward Banfield,* City Politics *(Cambridge Mass.: Harvard University Press, 1963), as quoted in Robert Perlman and David Jones,* Neighborhood Service Centers, *Office of Juvenile Delinquency, Welfare Administration, U.S. Department of Health, Education, and Welfare, 1967, p. 8.*

[7] *Alexander B. Callow, Jr.,* The Tweed Ring *(New York: Oxford University Press, 1966) pp. 104-105.*

[8] *Callow, pp. 105-106.*

[9] *See, for example, Perlman and Jones, p. 37.*

[10] *"The Advisory Committee on HEW Relationships with State Health Agencies," Report to the Secretary, U.S. Department of Health, Education, and Welfare, December 30, 1966, p. 53.*

[11] *"OSTI Revised Decentralized Training Paper,"* Organization for Social and Technological Innovation, *Apr. 30, 1969, p. 53.*

[12] *Perlman and Jones, p. 82.*

[13] *"Neighborhood Organizational Units of the Community Action Agency,"* Community Representation in Community Action Programs, *Report No. 4, Florence Heller Graduate School for Advanced Studies in Social Welfare, Brandeis University, Nov. 1968, p. 8.*

[14] *Kirschner Associates,* A Description and Evaluation of Neighborhood Centers, A Report for the Office of Economic Opportunity, *Dec. 1966, p. 69; "Community Representation in Community Action Programs," Report No. 5, Final Report, The Florence Heller Graduate School for Advanced Studies in Social Welfare, Brandeis University, Mar. 1969, pp. 74-75; Howard W. Hallman,* The Community Action Program—An Interpretive Analysis of 35 Communities, Examination of the War on Poverty, *vol. IV, U.S. Senate Committee on Labor and Public Welfare, September, 1967, p. 908.*

[15] *Edward J. O'Donnell and Catherine S. Chilman, "Poor People on Public Welfare Boards and Committees,"* Welfare in Review, *May-June 1969, pp. 1-9.*

[16] *Kirschner Associates, p. 47.*

[17] *Kenneth B. Clark, "Urban Crises—Gimmicks vs. Serious Programs," paper presented at the Annual Forum of the National Conference on Social Welfare, New York City, May 26, 1969, pp. 6-7.*

[18] *Kirschner Associates, p. 32.*

[19] *"Summary and Recommendations,"* A Study of the Neighborhood Center Pilot Program, *prepared for the Executive Office of the President, Bureau of the Budget, Abt Associates Incorporated, vol. 1, Apr. 30, 1969, p. 11.*

[20] *Perlman and Jones, p. 27.*

[21] *See Hobart A. Burch and Edward Newman, "A Federal Program for Neighborhood Services," paper presented at the national conference on social welfare, San Francisco, May 27, 1968; Thomas H. Walz "The Emergence of the Neighborhood Service Center,"* Public Welfare, *Apr. 1969, pp. 147-156; and*

Michael S. March, "The Neighborhood Center Concept," Public Welfare, Apr. 1968, pp. 97-111.

[22] See also Kirschner Associates, pp. 41-42, and "An Approach to Measuring the Impact of Existing Service Systems on Problems of Urban Poverty," Greenleigh Associates, Inc., New York, Chicago, pp. 1-8, for still other schemes for evaluation.

[23] Obviously, the major studies reviewed here vary considerably: for example, Perlman and Jones studied 20 centers operating six major programs; Kirschner Associates studied 20 OEO centers; Abt Associates studied 13 centers sponsored jointly by five Federal Departments; and Brandeis University studied 54 OEO centers as part of its study of resident participation in community action programs. Thus, these preliminary findings reflect the experience of neighborhood centers supported through Federal programs—primarily OEO. They do not necessarily speak to the long experience of traditional settlement houses, for example, and should be regarded as tentative pending the outcome of such further systematic research as is underway in the Social and Rehabilitation Service, U.S. Department of Health, Education, and Welfare, and the Office of Economic Opportunity.

[24] Kirschner Associates, p. 15.

[25] Perlman and Jones, p. 30.

[26] Perlman and Jones, p. 30.

[27] Perlman and Jones, p. 41.

[28] Perlman and Jones, p. 81.

[29] Kirschner Associates, p. 24.

[30] "An Evaluation of the Thirteen Neighborhood Service Programs," A Study of the Neighborhood Center Pilot Program, prepared for the Executive Office of the President, Bureau of the Budget, Abt Associates Incorporated, vol. 2, part 2, Apr. 30, 1969, p. 41.

[31] Perlman and Jones, p. 26.

[32] Perlman and Jones, p. 26.

[33] Perlman and Jones, p. 33.

[34] Perlman and Jones, p. 40.

[35] Kirschner Associates, p. 17. See also, Charles F. Grosser, "Helping Youth—A Study of Six Community Organization Programs," Office of Juvenile Delinquency and Youth Development, Social and Rehabilitation Service, U.S. Department of Health, Education, and Welfare, 1968, p. 57.

[36] Perlman and Jones, p. 31.

[37] Kirschner Associates, p. 26.

[38] Perlman and Jones, p. 26.

[39] Abt Associates, vol. 2, part 2, pp. 52, 110.

[40] Perlman and Jones, p. 30.

[41] Kirschner Associates, pp. 24, 27.

[42] Brandeis University, Report No. 5, pp. 74-75.

[43] Brandeis University, Report No. 4, p. 9.

[44] Brandeis University, Report No. 4, Appendix C.

[45] Abt Associates, vol. 2, part 2, p. 22.

[46] Abt Associates, vol. 2, part 2, p. 101.

[47] Kirschner Associates, p. 14.

[48] Kirschner Associates, p. 15.

[49] Kirschner Associates, p. 33.

[50] Perlman and Jones, p. 34.

[51] Kirschner Associates, p. 45.

[52] Perlman and Jones, p. 37.

[53] Abt Associates, pp. 52-54.

[54] Abt Associates, p. 144.

[55] Perlman and Jones, p. 37.

[56] Kirschner Associates, p. 34.

[57] Abt Associates, vol. 2, part 2, p. 40.

[58] Abt Associates, vol. 2, part 2, p. 145.

[59] Kirschner Associates, p. 44.

[60] Perlman and Jones, p. 37.

[61] Perlman and Jones, p. 34.

[62] Abt Associates, vol. 2, part 2, p. 90.

[63] Perlman and Jones, p. 40.

[64] Perlman and Jones, p. 34.

[65] Kirschner Associates, p. 34.

[66] Brandeis University, Report No. 4, p. 12.

[67] Kirschner Associates, p. 44.

[68] Abt Associates, Vol. 1, p. 14.

[69] Kirschner Associates, p. 53.

[70] Perlman and Jones, p. 75.

[71] Abt Associates, vol. 2, part 2, p. 22.

[72] Abt Associates, Vol. 2, part 2, pp. 76, 79.

[73] Perlman and Jones, p. 29.

[74] Abt Associates, vol. 2, part 2, p. 126.

[75] Abt Associates, vol. 2, part 2, p. 127.

[76] Abt Associates, vol. 2, part 2, p. 43.

[77] Abt Associates, vol. 2, part 2, p. 6.

[78] Abt Associates, Vol. 2, part 2, p. 42.

[79] Kirschner Associates, p. 25.

[80] Kirschner Associates, Appendix V, table 7.

[81] Kirschner Associates, p. 26.

[82] Kirschner Associates, p. 50.

[83] Perlman and Jones, p. 78.

[84] Brandeis University, Report No. 4, p. 12.

[85] HARYOU-ACT, quoted in Perlman and Jones, p. 53.

[86] Perlman and Jones, pp. 49-51.

[87] Kirschner Associates, p. 17.

[88] Clark, p. 15.

[89] Catherine S. Chilman, Growing Up Poor, Welfare Administration Publication No. 13, U.S. Department of Health, Education, and Welfare, May, 1966.

[90] Perlman and Jones, p. 51.

[91] Abt Associates, p. 91.

[92] Perlman and Jones, p. 51.

[93] For a recent attempt to measure changes in participants, see Louis A. Zurcher, Jr., "Social-Psychological Changes Among OEO Indigenous Leaders as a Result of 'Maximum Feasible Participation'," paper presented to the Society for the Study of Social Problems, American Sociological Association Meetings, Boston, Aug. 25, 1968.

[94] Brian W. H. Wharf, "Boundary Personnel: An Exploratory Study of their Role Responsibilities in the Interorganizational Relationships of a Multi-Service Center," unpublished doctoral dissertation, Brandeis University, June 1969.

[95] Perlman and Jones, p. 61.

[96] Hallman, p. 900.

[97] Kirschner Associates, p. 97.

[98] Peter Marris and Martin Rein, Dilemmas of Social Reform (New York: Atherton Press, 1967), p. 168.

[99] Nathan E. Cohen, "Building a Social Movement Among the Poor," (discussion) in John B. Turner, ed., Neighborhood Organization for Community Action, National Association of Social Workers, New York, 1968, p. 71.

[100] Lee Rainwater, "Neighborhood Action and Lower-class Life-styles" (discussion) in Turner, p. 72.

[101] Cohen in Turner, p. 71.

[102] Perlman and Jones, p. 40.

[103] Grosser, p. 58.

[104] Brandeis University, Report No. 4, p. 5.

[105] Kirschner Associates, p. 22.

[106] Perlman and Jones, p. 72.

[107] Kirschner Associates, p. 25.

[108] Hallman, p. 900.

[109] Richard A. Cloward and Richard M. Elman, "Advocacy in the Ghetto," Trans-action, Dec. 1966, p. 109.

Predicting Use of Public Assistance

An Empirical Study

Oliver Moles

Public assistance money payments are provided to over 10 million persons in the United States by Federal, State, and local governments. The largest of the programs through which assistance is provided is aid to families with dependent children (AFDC). About 6.5 million recipients—primarily children in families headed by mothers—are served by this program. (See "Public Assistance Statistics, June and July 1969, July," page 00.) Over the 5 years, 1963-67, the AFDC program increased by 38 percent.

Despite the size of the program, we are just beginning to know something about the kinds of persons who get public assistance. The social and demographic characteristics of AFDC recipients have been recorded from time to time,[1] but most studies have not permitted comparisons of recipients with other low-income persons. A national AFDC study supported by the Social and Rehabilitation Service, U.S. Department of Health, Education, and Welfare (HEW), will be available soon. And a joint report of the N.Y. State Department of Social Services and HEW, entitled "The Administration of Aid to Families With Dependent Children in New York City, November 1968-February 1969," which was released to the Congress in September, describes the trend in AFDC in New York City. But neither of these studies permits comparisons of recipients with other low-income persons.

The study on which this article is based represents an effort to fill a part of the gap in knowledge by examining social and psychological variables that may dispose some low-income parents but not others to seek and obtain public assistance.

The study on which this article is based examines some of the social and psychological variables that may dispose some low-income parents but not others to seek and obtain public assistance. If such variables can be identified in broadly based samples, it may be possible to predict the trend of caseloads more nearly accurately than is now possible. The variables used in this study, which presumably are the circumstances that dispose some families to seek and to get public assistance, are eligibility factors, knowledge of public assistance, attitudes toward public assistance, initiative and aspirations, alternatives to public assistance, history of family poverty, and length of residence in a location.

Study design

The data for this analysis came from a study of school and community relations in Detroit. Interviews conducted early in 1963 with a random sample of 1,021 mothers of 5th- and 6th-grade schoolchildren in 12 inner city school districts are the principal data source.[2] In addition, the records of the city and county public welfare departments were studied to determine whether the families had received public assistance at any time before 1965.[3] The only likely categories of assistance were AFDC from the county or general assistance from the city, which aided both broken and intact families (in April 1964 Michigan began assisting intact families with unemployed parents through AFDC). In all, 31 families had received AFDC or general assistance of either kind at some time in the approximately 21 months between the 1963 interviews and the end of 1964 but had no record of receiving assistance in the 12 months preceding the interviews. By research design, only families that had lived in the Detroit area for at least 2 years (to assure residential eligibility for assist-

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ance) and had incomes under $6,000 in 1962 were selected.

Of the 31 families, 28 could be individually matched with 28 others who had not received assistance during the 21 months after the interviews. The aided families had an average of 7.25 months of public assistance in this period. The members of each matched pair were of the same race, marital status, and income level, and had about the same number of children under 18 years of age living at home. (In two pairs family income could only be matched within $2,000, and in 20 pairs there was a difference of one child.) Thus, comparisons between the 28 matched pairs control simultaneously for the effects of all four variables.[4] As all except race are used to determine eligibility for assistance, the pairs were generally matched for eligibility requirements.

The distribution of cases by family income and number of children at home is presented below.

Matching variables	Received public assistance	
	Yes	No
Family income for 1962		
Under $1,000	3	2
$1,000–$1,999	2	3
$2,000–$2,999	3	3
$3,000–$3,999	8	8
$4,000–$4,999	5	6
$5,000–$5,999	7	6
Mean income	$3,607	$3,571
Children in household 0–18 years old		
1	4	0
2	1	5
3	5	4
4	4	3
5	2	4
6	3	6
7	6	4
8	2	1
9	1	0
10 or more	0	1
Average number of children	4.7	4.9

Even given the broader matching limits for income and family size, recipient and nonrecipient families differed little by mean income and the average number of children. Income was moderate for most: in 1962 over two-thirds in each set of families had incomes between $3,000 and $6,000, but in these relatively large families, which approached five children on the average, even incomes over $3,000 a year could not have gone very far.

As a whole, the study families were intact; the husbands were living at home in over three-fourths of both sets (22 pairs). About two-thirds (18 pairs) were Negro. The high proportion of Negroes raised the possibility that they were overrepresented in the sample, but such was not the case because 56 percent of the 408 nonrecipient families in the pool used to locate matching cases were also Negro. Nevertheless, to avoid possible social and cultural differences that could complicate the analysis, each family was matched on race.

Eligibility factors

Eligibility based on income is certainly one of the most important determinants of who receives public assistance. To illustrate, in a large-scale study in California, it was impossible to find comparison families in the same areas who were as poor on the average as those who got assistance.[5] Family size, residence requirements, and other aspects also help determine eligibility, and 29 States exclude most intact families from AFDC.

The most obvious explanation of why one set of families in the study received assistance and the other did not is that the aided families were at some time eligible for public assistance and the others were not. The two groups might even have been different at the time of the interview. On investigating this possibility, it was found that in 12 of the 20 pairs of families with unequal numbers of children, the recipient families had fewer children and hence were *less* likely to be eligible at that time. Differences in income within the thousand dollar intervals might account for differences in eligibility. The nonrecipient families might also have had unreported income, perhaps from sources not usually considered. To account for all income, the study question about income was phrased thus: "About what was your *total family income* from any source last year—1962—including all things such as wages, profits, interest, government payments, and other sources for you and your husband (and others who work and share expenses)?" With such explicit reference to the family unit and to various sources of income, it seems improbable that the actual and reported 1962 income of the families differed appreciably.

There was, however, a difference in employment levels. Seven recipient families were headed by unemployed men but only one nonrecipient family. Seven recipient but only four nonrecipient husbands worked over 40 hours a week. The data on the men's employment (table 1) indicate a statistically significant relation-

Table 1. Variables closely affecting determination of eligibility for public assistance

Variables	Received public assistance	
	Yes	No
Husband's weekly work hours		
Not working	7	2
Under 33 hours	0	1
33-40 hours	11	12
41-48 hours	1	3
Over 48 hours	3	4
Total	22	22
(15 unequal pairs, T=30.5, p=.053)		
Weeks husband out of work in 1962		
None	9	12
1-9 weeks	4	1
10-19 weeks	3	0
20-29 weeks	3	1
30-39 weeks	0	3
40-49 weeks	2	0
50-52 weeks	1	5
(15 unequal pairs, T=47, p not significant)		
Husband's usual occupation		
White collar	0	2
Craftsmen, foremen	5	1
Operatives	11	15
Laborers, private household and service workers	5	4
Farmers	0	0
Never worked or don't know	1	0
(16 unequal pairs, T=50, p not significant)		
Husband's education		
4 years or less	4	5
5-8 years	8	8
9-11 years	5	6
High school graduate or more	5	3
(16 unequal pairs, T=45.5, p not significant)		

ship among the 22 families headed by men: husbands in recipient families had fewer hours of work a week. Thus, shorter hours of employment for the head of the family characterized more of the intact recipient families than nonrecipient families.

The employment pattern of the husbands in the previous year, 1962, is more complicated. A few more of those in the nonrecipient families had never been unemployed or had been out of work 30 weeks or more, and a few more of those in the recipient families were likely to have had up to 29 weeks of unemployment. The differences, however, were not statistically significant.

Although experience with unemployment is generally more common in lower level occupations, it is not possible to predict the use of public assistance from the husband's usual occupation. Table 1 indicates no significant difference between the recipient and the nonrecipient families; three-fourths or more of the husbands in each group were in semiskilled and unskilled occupations. Nor is the husband's educational level related to the use of public assistance. Over half of both sets of men had never attended high school, and fewer than a quarter of either had graduated from high school (see table 1).

To summarize the findings about eligibility, the differences in current employment levels indicate that the families who later received public assistance were even at the time of the interview closer to being eligible than the others. Though this is not conclusive evidence of greater need at the time of obtaining assistance, it is consistent with such an interpretation.

Knowledge of public assistance

Eligibility does not appear to be the sole determinant of who receives public assistance. It may also depend on who knows about the availability of assistance. In 1960, for instance, only about half the people in the United States who were eligible for public assistance were receiving it.[6] And in 1964 a study of urban low-income residents found one in seven unable to say where to get "welfare money."[7]

One way families learn about public assistance is through contact with public welfare agencies. In this study 13 aided and eight unaided families had some recorded contact with the local public welfare agencies before the interview, but both numbers represent minorities of each group, and the differences are not statistically significant. None of the unaided had been denied assistance after the interview.

There are other ways to learn about public assistance besides direct contact, of course. In the interviews the mothers were asked their opinion about the kind of job the employees of the "ADC or Detroit Welfare Department" were doing. Only 15 expressed no opinion—nine in the aided and six in the unaided families (table 2)—indicating that most of the unaided had some knowledge of agency operations gained without direct personal experience. Differences in knowledge, there-

fore, do not seem to account for the use of public assistance.

Attitudes toward public assistance

Some eligible persons may be well informed about public assistance but unwilling to seek it because of negative feelings about the program, the agency staff, or recipients. As shown in table 2, two interview questions tapped attitudes toward public assistance. On the kind of job being done by the employees of the "ADC or Detroit Welfare Department," 11 recipient and 16 nonrecipient mothers said "good" or "excellent." Attitudes were more often favorable than unfavorable; those of the nonrecipient mothers were a little more likely to be favorable. To a second statement, "Any able-bodied individual who refuses to take a job should not receive assistance," almost all mothers agreed—27 recipients and 24 nonrecipients. The differences are not statistically significant for either question. Favorable views toward public assistance workers were in contrast to the nearly unanimous rejection of the idea of assistance for the voluntarily unemployed.

The strongly similar views of recipient and nonrecipient mothers on both questions suggest that attitudes toward public welfare workers and potential recipients do not affect the decisions that lead to public assistance. In fact, a few more nonrecipients than subsequent recipients felt favorable toward public assistance.

Initiative and aspirations

If people prize initiative and self-sufficiency, they may prefer to fend for themselves, even though their efforts net only enough income for marginal subsistence. A recent study, however, points in the other direction: more AFDC than other low-income mothers had high aspirations for their children and more AFDC children reported that their mothers pushed them to do better school work.[8]

Table 2 presents several kinds of information from the interviews used to test the proposition that people who seek public assistance lack the initiative and aspirations that help others attain and maintain economic self-sufficiency. An index of fatalism was constructed by combining four-point scale responses to three questions bearing on the belief that effort can alter one's life.[9] The results show that very few of the respondents were strongly fatalistic and that there was no tendency for the recipient mothers to be more fatalistic. Instead, a nondirectional prediction, significant at the .05 level, would have shown that the

Table 2. Use of public assistance and indicators of initiative, aspirations, and attitudes toward public welfare

Indicators	Received public assistance	
	Yes	No
Opinion of job done by AFDC or Detroit Welfare Department		
Excellent	1	5
Good	10	11
Fair	3	2
Poor	5	4
Don't know	9	6
(7 unequal pairs, T = 7, p not significant)		
Able-bodied person who refuses job should not receive assistance		
Strongly agree	26	19
Probably agree	1	6
Probably disagree	0	2
Strongly disagree	1	1
(9 unequal pairs, T = 4, p not significant)		
Degree of fatalism		
Strong	0	2
Moderate	12	16
Weak	12	9
Absent	3	1
Missing data	1	0
(23 unequal pairs, T = 71.5, p not significant)		
Contacted city agencies about neighborhood services		
Yes	4	4
No	24	24
(8 unequal pairs, X = 4, p not significant)		
Voted in previous gubernatorial election		
Yes	16	15
No	12	13
(15 unequal pairs, X = 7, p not significant)		
Highest annual family income expected		
Under present income	0	2
About same	14	9
Somewhat more than present	6	11
Much more	3	2
Don't know	5	4
(14 unequal pairs, T = 49, p not significant)		
Education wanted for child		
Some high school without graduating	2	0
Finish high school	7	3
Trade school or technical training	8	13
1 or 2 years of college	3	2
Finish college	7	8
Professional or graduate school	1	2
(20 unequal pairs, T + 78, p not significant)		

Table 3. Potential sources of private aid, parent's occupation, duration of residence, and use of public assistance

Source	Received public assistance	
	Yes	No
Relatives in Detroit area		
None	2	1
1 - 2	9	4
3 - 4	2	5
5 - 6	2	7
7 - 9	2	2
10 or more	9	7
Missing data	2	2
(26 unequal pairs, T = 167, p not significant)		
Attendance at religious services in past year		
Never	4	3
Less than once a month	4	1
Once or a few times a month	8	7
Once a week	6	10
Several times a week	6	7
(21 unequal pairs, T = 82, p not significant)		
Organizations belonged to		
None	10	11
One	9	9
Two	6	5
Three	2	1
Four or more	1	2
(19 unequal pairs, T = 94.5, p not significant)		
Father's main job status when mother was growing up		
White-collar worker	4	1
Craftsman or foreman	5	4
Operative	5	7
Private household or service worker	5	1
Laborer	4	5
Farmer	4	8
Unknown	1	2
(17 unequal pairs, T = 50.5, p not significant)		
Years lived in Detroit area		
2 - 9	9	4
10 - 19	7	16
20 - 29	5	7
30 - 39	2	0
Lifetime	5	1
(19 unequal pairs, T = 62.5, p not significant)		

recipient mothers were somewhat *less* fatalistic.

Concerning actual efforts to change one's circumstances, the groups did not differ significantly in the number of times they reported contacting city agencies about neighborhood services "like street cleaning, street repair, and garbage collection, parks and recreational facilities. . . ." Only four of each set of women had contacted city agencies about such matters.

On a second measure of overt initiative—voting in the previous election for State governor—the figures in table 2 show that majorities of about the same size in both groups reported voting. Thus, on both indicators there is no significant difference in the number of mothers reporting overt initiative and efforts to influence events that might change their lives.

Concerning specific aspirations, each mother was asked to name the highest annual income she expected her family to attain. Fourteen of the recipient and 11 of the nonrecipient mothers did not expect to attain levels higher than they had. However, concerning educational aspirations, about 40 percent of each group wanted their children to go to college and all but two mothers wanted them to finish high school. The differences for both questions are not statistically significant (table 2). Hence, for income and educational aspirations and measures of overt initiative, the recipient and the nonrecipient mothers showed no appreciable difference. Only a tendency for the recipient mothers to be less fatalistic differentiated the groups.

Alternatives to public assistance

Aside from the income of husband and wife, many families may rely in time of need on economic assistance from relatives and, perhaps, even from organizations such as a church to which they belong. The role of mutual aid among relatives—from money to child care to advice—has been documented by a series of studies.[10] If significant goods, services, and money are provided for people with marginal incomes from such sources, the nonrecipient families in the study might have been using them to a greater extent than the recipient families. However, the relatives of poor people may be poor themselves and not able to provide substantial help.

Most of the study families had no members living with them other than husband, wife, and children: this was true for 22 of the recipient and 26 of the nonrecipient families. When relatives living anywhere in the Detroit area were considered, the picture changed somewhat: 21 nonrecipient but only 15 recipient families had more than two. The differences (table 3) are not statistically significant. A direct test of the frequency of family assistance was afforded by the question, "Have you received any help from any relatives or family members?" Fifteen recipient and 20 nonrecipient mothers said yes, but the difference is not significant (11 unequal pairs, sign test X = 3).

Formal organizations, especially those set up to advance the moral or material well-being of their members, may also be sources of assistance. Participation in the activities of religious organizations can provide a member with an opportunity to express his needs to leaders and other fellow members. The comparison in table 3 points up a tendency for nonrecipient families to attend religious services more often than recipient families: 17 nonrecipient families attended once a week as compared to 12 of the AFDC, but the differences are not statistically significant. As to the clubs and organizations the women belonged to, 10 from recipient and 11 from nonrecipient families belonged to none; nine in each set belonged to one, and the rest belonged to more than one (see table 3). The husbands belonged to more organizations than their wives, but the number did not vary significantly from set to set (data not shown).

The various measures of family relationships and organization participation failed to demonstrate any reliable differences in involvement between the two sets of families. But the tendency for the recipient families to have fewer relatives in the area, to have received help from relatives less often, and to have attended religious services less often suggests that the use of relatives and organizations may be worth further study. Because this study obtained no information on the important question of the actual economic resources of relatives, this too is an important point for study. And because none of the questions concerning organizations directly asked about aid sought or received, the evidence here is not so direct as would be desirable.

The cycle of poverty and dependency

Many persons argue that poverty and dependency perpetuate themselves from generation to generation because the poor are plagued from birth onward by very limited personal resources and opportunities. If this argument is true, public assistance recipients should have more poverty in their family histories than other low-income families.

Three kinds of data from the study bear on this argument: the childhood home life of the respondent, the childhood home life of her husband, and the occupation of her father. Fourteen of the recipient and 11 of the nonrecipient mothers were from broken homes; that is, they had not lived with both parents from birth to age 17. For most pairs there was no difference in childhood living arrangements: only 10 were unequal. In nine of the recipient and 14 of the nonrecipient intact families, the husband had not lived with both his parents throughout childhood. Again, with only 10 unequal pairs, there was no difference. About half of each set of women had been raised in families whose heads were in low status and income occupations—farmers, laborers, or private household or service workers (table 3). A few more of the recipient than nonrecipient mothers were daughters of farmers and laborers, but the differences are not significant. Thus, based on this limited and indirect set of measures, there is no evidence that the parents in recipient families experienced more poverty in their childhood.

Newcomers and public assistance

Migration may be a reason for families seeking public assistance. Recent migrants, particularly from the South, are often charged with contributing disproportionately to the public assistance caseload in the more prosperous Northern States and of deliberately migrating to become public assistance recipients or to receive higher assistance payments. Studies in Baltimore and Cook County, Ill. (Chicago), do not show a disproportionate number of newcomers in the caseload,[11] but the charge persists.

Though all the families in this study had lived in the Detroit area for at least 2 years before the interview, still some might have migrated in the hope of obtaining jobs and had had to turn to public assistance when unemployment persisted. The data in table 3 do not support this line of reasoning, however. A few more of the aided women had lived in the area a short time, but a few more had also lived there a long time or a lifetime. Nor was the husband's duration of residence a factor: only three men in the recipient and three in the nonrecipient families had lived in the area less than 10 years. Differences in both cases are not significant, and the data certainly do not support the idea that recent migrants are overrepresented in the caseload.

Discussion of the findings

This article has presented data on a series of social and psychological characteristics of low-income families in relation to the use of public assistance by half of them. Among the possible explanations for receiving assistance explored—eligibility, knowledge of public assistance, low initiative and aspirations, no alternatives to public assistance, the cycle of poverty and dependency, and migration—only two important and statistically significant differences came forth. First, more of the intact recipient families were headed by men who had recently worked fewer hours than the men in the nonrecipient group. Second, the recipient mothers

tended to be less fatalistic than the others. Otherwise, the predictions, based on a variety of explanations for dependency, were not supported.

Although the study raises questions about the adequacy of these explanations, it has definite limitations. Cases in only one city were studied, and the 28 recipients of public assistance were selected on a half dozen criteria rather than being broadly representative of all new public assistance cases. Had the study taken in more time, some of the nonrecipient families might have become recipients. On the one hand, the small sample size also means that differences had to be large to be statistically significant, thus reducing the likelihood of finding significant results. On the other hand, the pair matching ruled out simultaneously the possible influence of extraneous variables. But the most important limitation was the impossibility of comparing families at the exact points where some sought aid. Although the conditions studied were very similar between groups at the time of the interview, the potential recipient husbands might have left their families more often, thus dwindling family income between the time of the study and the point of applying for assistance.

The importance of income is reflected in the findings on recent weekly hours of employment. A much larger California study of low-income intact families provides a variety of evidence as to the more extensive unemployment history of families receiving assistance.[1] [2] In that study the recipient husbands were more likely to mention ill health and the lack of skill or training as difficulties in getting a job, thus suggesting some of the circumstances that may underlie employment problems. This finding, of course, is not surprising, and much government and private effort and programs are directed toward job training, placement, and health care.

The families in the present study who turned to public assistance may have had fewer alternative economic resources than others. The findings here are not statistically significant, but the consistency of the trends suggest that relatives and religious organizations may help those who do not obtain public assistance more than those who do.

Some of the background variables were not subject to change in the period after the interview—length of residence in the area and the marital and occupational status of the respondents' parents. It is on attitudes that experience after the interviews may have had the greatest effect. Still, attitudes toward public assistance, aspirations, and initiative may predispose some persons to seek certain kinds of experience and to interpret them differently from persons with other attitudes.

A number of explanations for seeking public assistance received no support in this study. Regarding one of them, fatalism, there is evidence to suggest that public assistance recipients are less fatalistic than other low-income persons, that their seeking assistance may be an expression of their determination to do something about their economic circumstances. This study strongly suggests that more attention should be given to the importance of immediate economic problems and their remedies and less to unfavorable attitudes and family history.

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[1] *The most recent of such AFDC studies is "Characteristics of Families Receiving Aid to Families With Dependent Children," U.S. Department of Health, Education, and Welfare, Welfare Administration, Bureau of Family Services, Division of Program Statistics and Analysis, Apr. 1963. The final report of a similar 1967 study has not yet been issued, although a preliminary report is available.*

[2] *I am indebted to Eugene Litwak and Henry J. Meyer, principal investigators for this study, for making the data available. Their work was supported by contract No. 1796, from the U.S. Department of Health, Education, and Welfare, Office of Education.*

[3] *Data on public assistance histories were obtained from city and county (Wayne) records by the Detroit Department of Public Welfare, under a contract with the U.S. Department of Health, Education, and Welfare, Welfare Administration.*

[4] *The Wilcoxon matched-pairs signed-ranks test was used in the analysis wherever the data could be ranked. The test statistic is T. For data indicating the direction but not the size of differences, the sign test and its statistic X are used. (See Sidney Siegel,* Nonparametric Statistics for the Behavioral Sciences, *McGraw-Hill, pp. 68-83.) The .05 level of probability is used to reject the null hypothesis of no differences between samples. As the direction of the difference is predicted in all cases, the one-tailed test is used. When a substantial proportion of the pairs are equal in score, there is so much agreement between the samples that the sign and Wilcoxon test results do not apply to the complete samples. For the present study, only when two-thirds or more of all possible pairs are unequal were statistically significant differences taken to indicate divergence between the samples.*

[5] *See Robert C. Stone and Fredric T. Schlamp,* Family Life Styles Below the Poverty Line, *Institute for Social Science Research, San Francisco State College, 1966.*

[6] *Richard A. Cloward and Frances Fox Piven, "Migration, Politics, and Welfare,"* Saturday Review, *Nov. 16, 1968, pp. 31-35.*

[7] *Oliver Moles, Robert F. Hess, and Daniel Fascione, "Who Knows Where to Get Public Assistance?"* Welfare in Review, *Sept.-Oct. 1968, pp. 8-13.*

[8] *Oliver C. Moles, Jr., "Child Training Practices Among Low-Income Families,"* Welfare in Review, *Dec. 1965, pp. 1-19.*

[9] *The three statements comprising the fatalism index are these: "People can actually do very little to change their lives"; "Having to struggle for what you get in life is the best way to develop character"; and "Except when there is a depression, anyone in our country can get a job if he tries."*

[10] *For a recent empirical study, including the subject of mutual aid among relatives and discussion of earlier studies, see Bert N. Adams,* Kinship in an Urban Setting, *Markham Publishing Co., 1968.*

[11] *In Cook County, Ill., only 10 percent of a sample of AFDC families had lived in the State for under 5 years* (Addenda to Fact, Fallacies and Future: A Study of the Aid to Dependent Children Program of Cook County, Illinois, *Greenleigh Associates, Inc., 1960). Identical findings came from a New York City study conducted by Lawrence Podell* (Families on Welfare in New York City, Preliminary Report No. 4, *"Mother's Nativity and Immigration," Center for Social Research, City University of New York, 1967).*

[12] *Stone and Schlamp, op. cit.*

OAA Recipients in 1965

Health Conditions and Health Services

David B. Eppley

If one were to describe in a very brief way the main characteristics of elderly persons in the United States receiving old-age assistance (OAA), one fact would stand out, perhaps, above all the rest—these persons not only lack money and the things that money can buy, almost all of them also lack good health. In fact, poor health may be the major reason many of them must seek OAA. The 1965 national survey of OAA recipients, aspects of which are the subjects of three previous articles in *Welfare in Review*,[1] included items in a mail questionnaire about health conditions and impairments and the use of health services. Data from the recipients' responses to these questions are the substance of this article. The 1965 study was conducted by the (then) Bureau of Family Services, Welfare Administration, U.S. Department of Health, Education, and Welfare. The study universe consisted of recipients of money payments and of long-term institutional care. (Recipients who received only vendor medical care other than long-term institutional care were not included.)[2]

Data on the prevalence of health conditions and impairments and the use of hospitals and visits to physicians, based on self-reporting by respondents to mail questionnaires, are likely to be affected by the ability and willingness of the individual respondent to describe his condition and the health services he has received.[3] For example, it is likely that the respondent may not report fully and accurately concerning conditions and impairments not having a significant effect on his major activities. Nevertheless, self-reports on health conditions and impairments and on health services received can still be valuable in describing health problems among elderly persons. Any survey of medical care recently received by a population is likely to yield understatements (especially concerning hospitalization) because it omits those persons who have died of an illness under treatment, as well as understatements due to lapses in recall.

The 1965 OAA study involved the use of representative samples of OAA recipients and was not a complete census. The statistics presented in this article are, therefore, subject to sampling variability, and the figures may differ from the results a complete census would have obtained. However, because the research design involved a known probability of selection of a given recipient, the sampling variability can be readily ascertained.[4]

Health conditions and impairments

More than nine of every 10 (92.6 percent) of the OAA recipients reporting on their health indicated that they had one or more health problems. The three most prevalent diseases were arthritis or rheumatism, high blood pressure, and heart trouble. For two reasons—the advanced age of the recipients (the median age was 76.6) and the fact that more than two-thirds were women—it is not surprising that health problems were frequently reported and that the most common health problems reported are those associated with advanced age in general and those afflicting women of advanced age in particular. The 10 conditions most prevalent among the OAA recipients are shown in table 1.

Consultation with physicians

Recipients with high blood pressure, diabetes, or arthritis or rheumatism were those most likely to have consulted physicians about health conditions. More than nine of every 10 who reported having these conditions said they had visited their physicians because of them in the 6 months just before the survey:

Condition	Percent[1]
High blood pressure	95.1
Diabetes	94.6
Arthritis or rheumatism	93.0
Heart trouble	88.0

[1] *Does not include OAA recipients who did not report on visiting physicians.*

Hospitalization

About one of every eight recipients (12.4 percent) reported having been hospitalized overnight or longer during the 6 months immediately

before the study month. The median length of hospital stay was 9.8 days. Among the recipients whose diseases were specifically classified, diseases of the circulatory system accounted for the largest percentage of hospital stays. Next were diseases of the digestive system. Diseases of the bones and organs of movement (which include arthritis and rheumatism) were next to last—only 3.5 percent of the recipients who had been hospitalized were in this diagnostic group—although the category "arthritis and rheumatism" was the one most prevalent among the recipients. Table 2 gives the percentage distribution of recipients reporting hospitalization according to the conditions requiring hospitalization.

Table 1. Most prevalent health conditions, OAA recipients, 1965, in rank order

Health condition	Number of OAA recipients reporting condition per 1,000 OAA recipients
Arthritis or rheumatism	643
High blood pressure	468
Heart trouble	340
Blind or almost blind	225
Deaf or almost deaf	148
Paralyzed	97
Diabetes	95
Diseases of the digestive system	95
Kidney, bladder, and urinary diseases	71
Circulatory diseases[1]	40

[1] *Other than heart trouble, high blood pressure, and diseases of the arteries.*

Table 2. Percentage distribution of OAA recipients reporting hospitalization, 1965, by diagnostic group

Diagnostic group	Percent of recipients
Total	100.0
Diseases of the circulatory system	17.9
Diseases not elsewhere classified	17.4
Diseases of the digestive system	14.6
Diseases of the respiratory system	11.8
Diseases of the genitourinary system	9.3
Accidents, poisoning, violence	9.3
Diseases of the nervous system and sense organs	7.1
Allergic, endocrine, metabolic, or nutritional diseases	4.0
Malignant neoplasms	3.8
Diseases of the bones and organs of movement	3.5
Mental, psychoneurotic, and personality disorders	1.3

Population comparisons[5]

OAA recipients in this study were more likely than other elderly persons in the United States, as reported by the National Center for Health Statistics (NCHS) of the U.S. Public Health Service, to report a health condition or impairment.[6] More than nine of every 10 (92 percent) of the recipients reporting on their health said they had a health condition or impairment, as compared with only eight of every 10 persons 65 years of age and over in the Nation (82.8 percent) who reported suffering from a health condition.[7]

Table 3 shows the conditions and impairments more prevalent among OAA recipients than among the U.S. population 65 years of age and over, among the health conditions and impairments for which such comparisons were possible. Table 4 shows the conditions and impairments that were less prevalent among OAA recipients than among other elderly Americans.

Although several health conditions were reported more frequently in the NCHS data, the total number was apparently greater for the OAA sample. The OAA study indicates a total of 1,725 conditions per 1,000 noninstitutionalized OAA recipients, as compared with 1,543 conditions per 1,000 noninstitutionalized persons 65 and over, as reported in the NCHS data. (These differences should be interpreted with caution, however, for comparable data are available for only a small number of health conditions and impairments, and high blood pressure and heart trouble—two of the conditions included in these totals—are not mutually exclusive classifications.)

How are we to account for differences in the prevalence of morbidity between OAA recipients and other elderly persons in the United States? To answer this question definitively, we would have to compare adjusted morbidity rates for age and sex for OAA recipients and other elderly persons in the United States to determine what morbidity differences persist and compare the two groups by

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place of residence. However, data are not available for such comparisons. But on the basis of the information we have on the characteristics of OAA recipients, as contrasted with those of other elderly persons, and on differential morbidity rates for various segments of the U.S. population 65 and over, we can hypothesize explanations for the differences in morbidity rates for OAA recipients and other elderly Americans based on age, sex, region, place of residence, and family income.

Table 3. Conditions and impairments more prevalent among OAA recipients than among the U.S. population 65 years of age and over

Condition and impairment	OAA rate[1] (total)	OAA rate[2] (noninstitutionalized)	U.S. rate[3] (noninstitutionalized)
Arthritis or rheumatism	643	433	328
High blood pressure[4]	468	308	216
Heart trouble[4]	340	216	172
Blindness or near blindness	225	190	50
Deafness or near deafness	148	120	10
Paralysis	97	72	27
Diabetes	95	60	53
Kidney, bladder, urinary	71	72	46

[1] *Number of persons with specified condition per 1,000 OAA recipients, including institutionalized and noninstitutionalized recipients.* [2] *Number of noninstitutionalized persons with specified condition per 1,000 noninstitutionalized OAA recipients.* [3] *Number of specified chronic conditions per 1,000 noninstitutionalized persons in the U.S. population 65 and over. Source: based on* Vital and Health Statistics Data From the National Health Survey, *Series 10, No. 32, U.S. Department of Health, Education, and Welfare, U.S. Public Health Service.* [4] *Both classifications include hypertensive heart disease (International Classification of Disease Codes 440-443). Detailed information on the disease codes pertaining to these and other statistics as used in this article may be obtained from the National Center for Social Statistics, Social and Rehabilitation Service, U.S. Department of Health, Education, and Welfare, Washington, D.C. 20201.*

Table 4. Conditions and impairments less prevalent among OAA recipients than among the U.S. population 65 years of age and over

Condition and impairment	OAA rate[1] (total)	OAA rate[2] (noninstitutionalized)	U.S. rate[3] (noninstitutionalized)
Diseases of the digestive system	95	97	208
Diseases of the circulatory system[4]	40	40	164
Diseases of the respiratory system	45	46	157
Diseases of the nervous system	30	29	59
Diseases of the arteries	30	26	36
Malignant neoplasms	16	16	17

[1] *Number of persons with specified condition per 1,000 OAA recipients, including institutionalized and noninstitutionalized recipients.* [2] *Number of noninstitutionalized persons with specified condition per 1,000 noninstitutionalized OAA recipients.* [3] *Number of specified chronic conditions per 1,000 noninstitutionalized persons in the U.S. population 65 and over. Source: based on* Vital and Health Statistics Data From the National Health Survey, *Series 10, No. 32, U.S. Department of Health, Education, and Welfare, Public Health Service, June 1966, tables 26 and 34, pp. 55 and 63; and on unpublished data from the National Center for Health Statistics, U.S. Department of Health, Education, and Welfare, Public Health Service.* [4] *Except circulatory diseases classified elsewhere.*

Age differences.—OAA recipients included greater numbers of very old persons than did the other elderly persons in the population. Almost six of every 10 OAA recipients (57.5 percent) were 75 or over, but only a little more than a third (35 percent) of the elderly persons in the Nation were that old.[8] Because the prevalence of chronic disease increases with advancing age, the age differential between the two groups could account for at least part of the higher prevalence among the OAA recipients.

Sex differences.—There were relatively more women among OAA recipients than among all elderly persons in the United States. More than two-thirds (68.4 percent) of the recipients were women, but only a little more than half (55.8 percent) of the elderly population in general were women.[9] Women 65 and over in the United States were more likely than men in this age group to have health problems.[10]

The comparative rate was 810 for men with one or more chronic conditions and 843 for women with such conditions per 1,000 persons in the United States 65 and over. The greatest prevalence of health problems among OAA recipients could, therefore, be explained, partly, by differences in the sex composition of the two groups.

The differences in morbidity between OAA recipients and other elderly persons in the general population can partly be explained by these two facts: there were relatively more women among OAA recipients as compared with the general elderly population and health conditions are to some extent linked to sex. Our data suggest that the conditions to which women are subject more than men at ages 65 and over tended to occur more frequently among the

OAA recipients than among other elderly Americans. Heart conditions, high blood pressure, and arthritis and rheumatism—the three conditions most prevalent among OAA recipients—are more likely to strike women than men 65 and over in the U.S. population. The number of chronic conditions per 1,000 persons 65 and over in the United States was as follows:[11]

Condition	Men	Women
Heart condition	169	173
High blood pressure	95	222
Arthritis or rheumatism	253	393

Regional differences.—The regional distribution of the OAA recipients was considerably different from that of the general elderly population. Half (50.9 percent) of the OAA recipients lived in the South, where only a little more than a fourth (28.3 percent) of the general elderly population lived.[12] The highest regional morbidity prevalence rate for elderly persons in the United States, as reported in the NCHS data, was in the South.[13] The morbidity prevalence rate per 1,000 persons in the Nation 65 and over was as follows: Northeast 761; North Central 830: South 878; and West 848.

Residential differences.—Fewer OAA recipients than other elderly Americans lived in metropolitan areas.[14] Less than half (46.2 percent) of the recipients, but almost three-fifths (58.6 percent) of the population 65 and over, lived in metropolitan areas.[15] According to NCHS data, residents of nonmetropolitan areas were more likely than residents of metropolitan areas to have chronic health conditions.[16] The number of persons with one or more chronic conditions per 1,000 persons in the United States 65 and over living in metropolitan areas is 801; in nonmetropolitan areas the rate is 869 for nonfarm and 864 for farm areas.[16] Differences in place of residence are thus another characteristic that may account for differences in health problems between OAA recipients and the elderly in general.

Family income differences.—The very fact that they are receiving public assistance points up that OAA recipients are poorer than the general population 65 and over. NCHS data make it quite clear that the prevalence of health conditions in the United States is inversely related to family income:[17]

Annual income	U.S. rate[1]
Under $3,000	862
$3,000 - 3,999	846
$4,000 - 6,999	797
$7,000 - 9,999	783
$10,000 and over	763

[1] *Number of persons with one or more chronic conditions per 1,000 persons in the United States 65 and over.*

Greater poverty could, thus, be partly responsible for the fact that OAA recipients report more health problems.

A summing up

The data presented in this article on the health conditions of OAA recipients and on the health services they received should be considered as benchmark data inasmuch as the 1965 survey of OAA recipients was conducted in a "pre-Medicare" and "pre-Medicaid" period. (Medicare and Medicaid became effective on January 1, 1966.) It is, however, obvious that many OAA recipients had health problems at the time of the 1965 survey, and the question must be continually raised whether recipients who need hospital care, physicians' services, or other health services are able to obtain them. An important objective of future studies should be to assess the effect of Medicare and Medicaid on OAA recipients' health and health services.

A comparison of the reported prevalence of health conditions between OAA recipients and other elderly persons in the United States indicates that morbidity differences could be explained, at least in part, by the fact that OAA recipients tend to be older than other elderly Americans and are more likely to be women, to reside in the South and in nonmetropolitan areas, and to be poor. Each of these variables is independently associated with higher morbidity rates. The study data do not permit a definitive assessment of the variables accounting for morbidity differences, nor do they permit a determination of whether differences are cumulative in effect or whether some underlie others. Yet to be studied are such aspects as whether poverty in and of itself results in a higher prevalence of chronic conditions and, if so, through what intermediate processes it exerts its effects.

An even more important research question is that of the direction of causality, if poverty and illness are shown to be associated. The relatively poor health of OAA recipients is in many cases responsible for their needing OAA in the first place, as already pointed out. In a recent period (July-December 1967), voluntary reports received by the national Center for Social Statistics from 23 States indicate that illness, injury, or other impairments, or medical care costs were the principal reasons for

opening 26 percent of the OAA cases that began receiving assistance in that period.

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[1] *Shirlene B. Gray, "OAA Recipients in 1965: Demographic and Program Characteristics,"* Welfare in Review, *May-June 1969, pp. 11-20; David B. Eppley, "OAA Recipients in 1965: Data From Recipients' Mail Reports,"* Welfare in Review, *May-June 1969, pp. 21-26; Shirlene B. Gray, "OAA Recipients in 1965: Financial Circumstances,"* Welfare in Review, *July-Aug. 1969, pp. 13-18.*

[2] *The articles referred to in footnote 1 contain brief descriptions of the study universe, the State samples, and the methods of data collection. For other publications pertaining to this study, see* Findings of the 1965 Survey of Old-Age Assistance Recipients: Data by State and Census Division, Part I. Demographic and Program Characteristics, *U.S. Department of Health, Education, and Welfare, Welfare Administration, Bureau of Family Services, Division of Research, Washington, D.C., May 1967;* Part II. Data Obtained by Mail Questionnaire, *U.S. Department of Health, Education, and Welfare, Social and Rehabilitation Service, Sept. 1967; and* Part III. Financial Characteristics, *U.S. Department of Health, Education, and Welfare, Social and Rehabilitation Service, Apr. 1968.*

[3] *Cf.* Vital and Health Statistics Data From the National Health Survey, *Series 10, No. 32, U.S. Department of Health, Education, and Welfare, Public Health Service, June 1966, p. 17.*

[4] *The estimated sampling variability (or standard error) for the data obtained from the 1965 OAA Study may be obtained from the National Center for Social Statistics, Social and Rehabilitation Service, U.S. Department of Health, Education, and Welfare, Washington, D.C. 20201.*

[5] *Comparisons between OAA recipients and the general population 65 and over relate to noninstitutionalized persons in both populations, unless otherwise specified.*

[6] *Data on the general elderly U.S. population used throughout this article are from* Vital and Health Statistics Data From the National Health Survey, *op. cit.*

[7] *The percentage of noninstitutionalized OAA recipients with a health condition or impairment is an estimate based on the assumption that all recipients in nursing homes and other medical institutions had one or more health problems and that recipients in nonmedical institutions were as likely as all OAA recipients to have health problems. Cf.* Vital and Health Statistics Data From the National Health Survey, *op. cit., table 22, p. 48.*

[8] *Data for general elderly population based on* Vital and Health Statistics Data From the National Health Survey, *op. cit., table 21, p. 45.*

[9] Vital and Health Statitstics Data From the National Health Survey, *op. cit., table 34, p. 63.*

[10] Vital and Health Statistics Data From the National Health Survey, *op. cit., table 21, pp. 45-46.*

[11] Vital and Health Statistics Data From the National Health Survey, *op. cit., tables 26 and 34, pp. 55 and 66. These data are not rigorously comparable with data in table 3 of this article because of differences in classification of conditions. They do, however, illustrate the sex-relatedness of these conditions.*

[12] Vital and Health Statistics Data From the National Health Survey, *op. cit., table 34, p. 63.*

[13] Vital and Health Statistics Data From the National Health Survey, *op. cit., table 24, p. 52.*

[14] *The terms "metropolitan" and "nonmetropolitan" refer to standard metropolitan statistical areas (SMSA's). See* Standard Metropolitan Statistical Areas, 1967, *Executive Office of the President, Bureau of the Budget.*

[15] Vital and Health Statistics Data From the National Health Survey, *op. cit., table 34, p. 63.*

[16] Vital and Health Statistics Data from the National Health Survey, *op. cit., table 25, p. 54.*

[17] Vital and Health Statistics Data From the National Health Survey, *op. cit., table 22, p. 48.*

Use of AFDC by Eligible Families

A Predictive Model

FAMILIES ELIGIBLE for public assistance in Pennsylvania in 1968 sought aid in proportion to the size of their grants, the American Rehabilitation Foundation (ARF) found in applying a quantitative model for estimating the cost of the aid to families with dependent children (AFDC) program in Pennsylvania. The percentage of families potentially eligible for AFDC who actually received assistance in 1968 varied from 22 percent for families eligible for grants of less than $50 a month to 82 percent for families eligible for grants of $325 a month. This finding is consistent with that of a Baltimore study on which *Welfare in Review* reported last year ("Who Knows Where to Get Public Assistance?" September-October 1968). The Baltimore study found that the greater the family's need the more likely its members were to know where to get public assistance.

In developing the cost estimation model for the Pennsylvania Department of Public Welfare, ARF obtained estimates of two aspects: how many families eligible for AFDC were actually receiving assistance and the possible effect of an increase in the amount of payment on the percentage of families who would apply. Data from two sources were compared. First, the characteristics of families receiving AFDC were programmed into the model. From these characteristics the model computed the monthly grant for each family and counted the number of families in grant intervals of $25. Second, the characteristics of all families in the State were programmed into the model and the model determined whether or not each family would be eligible for AFDC and if eligible, the monthly grant. The characteristics of AFDC families were taken from the December 1967 AFDC study in Pennsylvania. Data on the characteristics of all families were taken from the *Current Population Reports, Consumer Income*, Series P.60, No. 53, Dec. 28, 1958. Statistics on the number of families in Pennsylvania were derived from households data contained in *Sale Management: The Marketing Magazine*, June 10, 1968. The statistics on households were modified to remove families obviously not eligible for AFDC such as unrelated persons living together and families without children.

The model works this way: for each $25 grant interval, the number

Table 1. Participation rates for AFDC families in Pennsylvania, by average monthly grant

Average monthly grant	Participation rates (percent)
$25	22
50	22
75	24
100	28
125	32
150	35
175	44
200	50
225	56
250	63
275	74
300	78
325	[1] 82
350	89
375	89
400	89

[1] *This is the highest grant under Pennsylvania's standards for 1968. The model estimates participation rates for higher grant intervals based on the rates for the lower intervals.*

Table 2. Maximum grant by family size,[1] Pennsylvania Department of Public Welfare

Family size	Food, clothing, shelter allowance	Shelter allowance (maximum)	Utilities allowance	Total allowance per month	Total allowance per year
1	$43	$32.80	$10.40	$86.20	$1,034.40
2	76	39.30	12.80	128.10	1,537.20
3	108	41.00	13.80	168.80	2,025.60
4	140	42.80	15.30	198.10	2,377.20
5	170	44.70	16.20	230.90	2,770.80
6	192	46.60	17.30	255.90	3,070.80
7	224	46.60	17.30	287.90	3,454.80
8	256	46.60	17.30	319.90	3,838.80

[1] *Food, clothing, and incidental allowances are a fixed amount (per person) per month. Shelter is the actual cost, subject to the maximum allowance. Utilities are a fixed allowance if they are paid for separately from shelter. The allowances for shelter and utilities vary by regions within the State. Statewide averages are shown here. Allowances effective for 1968.*

of families actually receiving AFDC is divided by the number of families computed by the model as potentially eligible for assistance. The ratio is an estimate of the percent of eligible families by monthly grants who are actually receiving assistance. The percent is the participation rate of eligible families. Of all eligible families in Pennsylvania only this percentage were actually receiving AFDC. The participation rates for families by the size of monthly grants are shown in table 1.

The model determines eligibility on the basis of income and other eligibility standards such as the employment status of parents. It does not include eligibility standards regarding ownership of real property or legally responsible relatives. For the Pennsylvania study, the model examined eligibility aspects not related to need such as employment status of parents, computed the economic need of the family, as defined by Pennsylvania's assistance standards, and compared this need in dollars to the family's income after all allowable deductions had been made.

The family's need is computed by totaling the amounts of allowances for food, clothing, and incidentals for each member of the family and adding the total to a utility allowance based on family size and a shelter allowance (actual shelter cost subject to a maximum, depending on the size of the family). The allowances used in computing the rates for the study were those in effect in Pennsylvania during 1968.

The model computes available income by examining each source of income, subtracting allowable deductions, and totaling the results. The allowance deductions are mainly on earned income and include social security, income taxes, an incentive deduction of $30, and a third of the remainder of the net income.

The model includes family size from one (an AFDC child living in a foster home or with some other kind of nonrecipient family) to eight and identifies 14 different family types, depending on the presence or absence of the parents and their employment status. The participation rates shown in table 1 are based on all family types and sizes. Individual participation rates schedules by each family type and size could also be obtained from the model.

The model used the finding that participation rates increase as grant size rises to estimate the cost of an increase in allowances due to higher participation because of larger grants. To this end, it computed the average monthly grant and applied the appropriate participation rate to the total number of potentially eligible families to determine the number who would very likely participate. This method, wherever applied, takes into account not only the expanded number of eligible families due to the increase in allowances but also the additional cost due to the greater number of families who apparently participate at higher grant levels.

Information on the complete model can be obtained from Seldon Todd, Director, Operations Research and Policy Systems Division, American Rehabilitation Foundation, 1800 Chicago Avenue, Minneapolis, Minn. 55404.

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Book NOTES

The Long Road to Unemployment Insurance

Unemployment Insurance: The American Experience, 1915-1935, *Daniel Nelson, University of Wisconsin Press, Madison, Wis. 54306, 1969, 305 pp., $10.*

MANY EUROPEAN cities and nations began in the 1890's to subsidize trade union plans paying out-of-work benefits. In 1911 the British Parliament passed an unemployment insurance plan. In the United States, as early as 1901, Charles Tuttle, a professor at Wabash College, proposed a plan of indemnification for workers displaced by machinery. For the next three decades, educators, industrial leaders, and social and political reformers advocated unemployment insurance in some form—but with little results. Americans were apparently reluctant to accept the inevitability of unemployment in an industrial society and the need for income maintenance for labor. Not until the mid-1930's did the Nation have compulsory unemployment insurance.

Many economists have explained the reasons for the Nation's reluctance to accept unemployment insurance. They are well summed up by Paul H. Douglas in *Social Security in the United States: An Analysis and Appraisal of the Federal Social Security Act* (McGraw-Hill Book Company, Inc., 1936): the belief that unemployment could be reduced to narrow limits by stabilizing industry; the feeling that unemployment insurance was a "debasing dole"; the

failure of labor to influence legislation; and the absence of a strong political party of the left. In *Unemployment Insurance: The American Experience, 1915-1935,* Daniel Nelson seeks to "show how and by whom this reluctance was overcome and how the results, the unemployment-insurance legislation of the mid-1930's, reflected the interests of the people who played major roles in bringing about the change."

Dr. Nelson organizes a large amount of material concerning the ideas and activities of many diverse persons around a simple theme: the United States was in conflict over the purpose of unemployment insurance. The Nation asked itself—Is the purpose of unemployment insurance to prevent unemployment (the "European approach") or to provide relief for the unemployed (the "American approach")? The final legislation was successful because it reconciled both ideas.

Active efforts to establish an unemployment insurance system in the United States, Dr. Nelson points out in his first chapter, began before World War I. The major organization behind the movement, the American Association for Labor Legislation (AALL), was active from about 1910 until the Social Security Act was passed in 1935. As early as 1916, the Association worked for unemployment insurance in the legislatures of Massachusetts and Illinois.

In his middle chapters Dr. Nelson describes the ideas and activities of three groups in the 1920's, when the "American approach" dominated: businessmen, organized labor, and social reformers in Wisconsin. After World War I businessmen were preoccupied with industrial efficiency and scientific management. Organizations like the American Management Association and pioneering businessmen like Howard Coonley, A. Lincoln Filene, and Henry Dennison argued that unemployment and high labor turnover were inefficient and costly. They urged businessmen to prevent unemployment. A few companies (23 between 1916 and 1934) went so far as to establish employment guarantee plans with unemployment-insurance funds. Dr. Nelson describes these plans in more detail than do most books on this subject.

Labor's attitude in the 1920's toward unemployment insurance was dominated by Samuel Gompers and his beliefs, which were close to the employers' prevention idea. But labor had its dissidents, and *Unemployment Insurance* contains a good chapter on the joint labor-management unemployment funds in the needle trades. However, I think Dr. Nelson strains at the "unifying principle" of his book when he says that the "needle trades officers combined the objectives of the New Emphasis employers with the aims of the conventional unemployment benefit plans." Although the needle-trades unions were pioneers in urging union-management cooperation and the prevention of unemployment, beginning in 1920, and were ultimately successful in reforming their industry's organization and production methods, they did not succeed through the unemployment funds, which were mostly pooled among employers.

Dr. Nelson discusses the history of unemployment insurance legislation in Wisconsin, beginning with the Huber bill in 1921, and describes the political maneuvering of individual reformers and groups—John R. Commons of the University of Wisconsin; the AALL; manufacturers; farm groups; and labor organizations. The results of their activity was the first public unemployment insurance law in the United States (Wisconsin, 1933), a law in which "prevention" was embodied in the provision for individual reserves.

The impact of the Depression greatly enlarged the audience of the social reformers. Social workers, clergymen, and other humanitarians turned from the problems of immediate relief to a long-term solution—unemployment insurance. Labor reversed itself. The argument now was not over the need for unemployment insurance but over what kind. The reformers split, not without bitterness, into three camps. The "preventionists" favored individual company reserves (businessmen, the AALL, the Wisconsin school). The others favored statewide pooled funds but were divided over whether to adhere strictly to insurance principles or to have State contributions.

Dr. Nelson details the struggle and conflict of these camps in State legislatures between 1930 and 1935 and in the U.S. Congress between 1933 and 1935. Before the Social Security Act was passed, three States provided for a 100 percent pooled State fund; one followed Wisconsin's example; and 22 made a "concession to unemployment prevention by including provisions for merit-rating or experience-rating. . . ." In the Congress the conflicting points of view were also reconciled, the effort having been led by political realists in the Congress; the pragmatic Secretary of Labor, Frances Perkins; and Edwin Witte, Executive Director of the Committee on Economic Security, a committee set up by President Roosevelt. In the final Federal-State law individual reserves were permitted and States were allowed a wide latitude in the type of experience-rating used.

My only serious criticism of *Unemployment Insurance* is that it may draw too sharp a line between prevention and benefits. Did most of the members of the Wisconsin school

believe that prevention was the principal reason for unemployment insurance, as Dr. Nelson implies? The theory that the price of a product should reflect its total cost, including that of unemployment, is another argument for individual reserves. I am not saying, of course, that the advocates of pooled funds were not justified in their fears that an individual reserve plan might not yield adequate benefits.

Unemployment Insurance should be particularly useful to a younger generation of economists and social workers. The classic books on the subject are economic analyses of the issues involved in determining the many provisions (not just financing) of an unemployment insurance system. This is a history. The detailed account of the difficulties faced, and ultimately overcome, by a past generation of reformers should provide valuable historical background. For the present, it may offer insight into the complexities involved in American attitudes toward income-maintenance in the absence of work.

Virginia Kyner Boman

Dr. Boman was formerly research associate, Institute of Social Order, St. Louis University, where she specialized in the economics of unemployment compensation.

New Audiovisual Materials On REHABILITATION

AUDIOVISUAL MATERIALS prepared for the 1969 National Citizens Conference on Rehabilitation of the Disabled and Disadvantaged, held on June 24-27 in Washington, D.C., are now available on loan without charge or by purchase. These 12 films and two filmstrip-records—listed below—are suitable for use by public service television, rehabilitation agencies, conferences on rehabilitation, schools, legislators, and civic clubs promoting rehabilitation. Several center on the problems of public assistance recipients and other poor persons.

To borrow materials or to obtain more information about their loan, write the following:

Office of Public Affairs
Social and Rehabilitation Service
U.S. Department of Health, Education, and Welfare
Washington, D. C. 20201.

Orders should include the number and title of film, dates needed, name of meeting, where to mail (name, title, and address), and telephone number (including area code number) of the person or organization making the request.

To purchase or to obtain more information about purchasing the materials, write the following:

Mr. Ralph Collett
National Audiovisual Center
Washington, D.C. 20201.

1. **Beating the Averages,** 16 mm. color film, 27 minutes, narrated by Raymond Burr. $91.25. Depicts the problems of persons confined to wheelchairs in moving about conventionally designed homes, office buildings, and factories.

2. **The Gap,** 16 mm. color film, 27 minutes. $91.25. Depicts the problems hampering the delivery of welfare and rehabilitation services, including lack of money and workers.

3. **A Demand to be Heard,** 16 mm. color film (film-a-graph), 28½ minutes. $96.25. Depicts the demands of recipients for a voice in planning and delivering the services they receive; includes examples of their involvement.

4. **Someone Who Cares,** 16 mm. color film, 11 minutes. $37.25. Depicts the rehabilitation of stroke victims.

5. **Anything for Kicks,** 16 mm. color film (film-a-graph), 11 minutes. $37.25. Depicts the problems of young drug addicts.

6. **Another Voice,** 16 mm. color film, 10 minutes. $34. Depicts rehabilitation after laryngectomy through esophageal speech.

7. **Those Who Stay Behind,** 16 mm. color film, 16 minutes. $55. Depicts the problems of the isolated disadvantaged rural family, particularly one with an afflicted child.

8. **The Step Up,** 35 mm. color filmstrip and record kit, 9 minutes. $10. Depicts health care for the afflicted child in a disadvantaged urban family.

9. **Not Sick Enough,** 16 mm. color film, 10 minutes. $35.75. Depicts the special problem of mental illness in the unnoticed neurotic person.

10. **Continuity of Rehabilitation Services,** 16 mm. color film, 10 minutes. $10. Depicts the contribution of a private business firm (an insurance company) to a comprehensive rehabilitation program in Newark, N.J.

11. **Making Ends Meet,** 16 mm. color film (film-a-graph), 11 minutes. $37.25. Depicts the successful operation of a day-care center in Perry, Ga., supported entirely by local contributions.

12. **ECCO,** 16 mm. color film, 7 minutes. $24.50. Depicts the financing of a neighborhood rehabilitation center in a poverty-stricken area of Columbus, Ohio.

13. **New Work for Greenville,** 16 mm. color film, 8 minutes. $27.75. Depicts job training for industrial survival in Greenville, Miss., with emphasis on industry's part in the rehabilitation process.

14. **Coordinated Rehabilitation Financing,** 35 mm. color filmstrip and record kit, 7 minutes. $10. Depicts a communitywide method of financing rehabilitation services in New Haven, Conn.

New Publications

U.S. Government

Publications for which prices are listed may be ordered from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402 (25 percent discount on orders of 100 or more). Payment must accompany order. Single copies of unpriced publications are available from the issuing agency.

Social and Rehabilitation Service

Eat well for you and your baby who is on the way. Children's Bureau. 1969, 4 pp., 10 cents. Presents a simple nutritional guide for expectant mothers.

Perspectives in public welfare: a history, by Blanche D. Coll. Office of Research, Demonstrations, and Training, Intramural Research Division. 1969, 90 pp., 70 cents. Reviews poor relief policies and practices in the United States from colonial times through the 1920's, tracing their roots to medieval practices and the Elizabethan Poor Laws. A full-length review of this publication will appear in a subsequent issue of *Welfare in Review.*

Publications and films. Office of Juvenile Delinquency. 1969, 9 pp. Catalog of selected items, with form for ordering single copies and release prints.

Research related to children: September 1968-March 1969. Children's Bureau, Clearinghouse for Research in Child Life. Bulletin 24, 1969, 143 pp., $1.50.

Who will take care of your child when you are in training or on the job? Children's Bureau. Publication No. 467, 1969, 12 pp., 15 cents. Gives instructions and advice on how to find day care for preschool children and how to handle problems arising from day care.

Non-Government

Direct inquiries and orders to the publisher or issuing agency.

Annual register of grant support: 1969. Academic Media, Inc., 10835 Santa Monica Blvd., West Los Angeles, Calif. 90025. 1969. 393 pp., $35. Presents a "guide to grant support programs of government agencies, foundations, and business and professional organizations."

Community life for the mentally ill: an alternative to institutional care, by George W. Fairweather and others. Aldine Publishing Co., 529 S. Wabash Ave., Chicago, Ill. 60605. 1969, 357 pp., $10. Describes a "lodge society" set up by released mental patients and the patients' eventual absorption by the neighborhood. (Project supported by the National Institute of Mental Health.)

Current research in voluntary social and health agencies in New York City: 1969. Research Department, Community Council of Greater New York, 225 Park Ave. South, New York, N.Y. 10003. 1969, 195 pp., $3. Reports on 151 projects conducted by 70 agencies.

Directory of agencies serving the visually handicapped in the United States. (16th ed.) American Foundation for the Blind, 15 W. 16th St., New York, N.Y. 10011. 1969, 343 pp., $6.

Disadvantaged child, vol. 2: Head Start and early intervention, Jerome Hellmuth, ed. Brunner/Mazel, Inc., 80 E. 11th St., New York, N.Y. 10003. 1969, 613 pp., $12.50. Presents chapters on scientific and theoretical problems, interspersed with chapters on Head Start.

Federal training and work programs in the sixties, by Sar A. Levitan and Garth L. Mangum. Institute of Labor and Industrial Relations, Michigan-Wayne State University, Ann Arbor, Mich. 48106. 1969, 465 pp., $9.50. Discusses training and work programs in the antipoverty program.

A followup study of adoptions: post-placement functioning of adoption families, by Elizabeth A. Lawder and others. Child Welfare League of America, Inc., 44 E. 23d St., New York, N.Y. 10010. 1969, 232 pp., $4. The first of two volumes, this book presents material based on a research project of the Graduate Department of Social Work, Bryn Mawr College, and the Children's Aid Society of Pennsylvania.

Foundations of practical gerontology, Rosamonde R. Boyd and Charles G. Oakes, eds. University of South Carolina Press, Columbia, S.C. 29208. 1969, 270 pp., $4.95. Considers the sociology of aging and special programs for the elderly.

Fringe benefits: wages or social obligation? an analysis with historical perspectives from paid vacations, by Donna Allen. New York State School of Industrial and Labor Relations, Cornell University, Ithaca, N.Y. 14850. 1969, rev. ed., 272 pp., $5 (paper). Discusses whether fringe benefits, as exemplified in paid vacations, are wages or a social obligation.

From dependency to dignity: individual and social consequences of a neighborhood house, by Louis A. Zurcher. Behavioral Publications, Inc., 525 W. 120th St., New York, N.Y. 10027. 1969, 100 pp., $5.95. Reports on a Menninger Foundation research project concerning the development of a neighborhood house to effect social change and to train poor people.

Game theory in the behavioral sciences, Ira R. Buchler and Hugo G. Nutini, eds. University of Pittsburgh Press, 3309 Cathedral of Learning, Pittsburgh, Pa. 15213. 1969, 200 pp., $8.95. Describes the application of game and graph theory and linear programming to anthropological data.

The Great Society's poor law: a new approach to poverty, by Sar A. Levitan. The John Hopkins Press, Homewood Campus, Baltimore, Md. 21218. 1969, 348 pp., $7.95. Discusses the development, organization, accomplishments, and failures of the Office of Economic Opportunity.

Green power: the corporation and the urban crisis, by George S. Odiorne. Pitman Publishing Corp., 20 E. 46th St., New York, N.Y. 10017. 1969, 196 pp., $5.95. Gives the views of a management consultant who urges business to help solve the urban crisis by training and employing the "unemployable."

A guide to medical care and administration, vol. 1: concepts and principles, by Beverlee A. Meyers. American Public Health Association, 1740 Broadway, New York, N.Y. 10019. 1969, rev. ed., 114 pp., $2.50. Provides a "comprehensive view [of the subject] as a starting point for the discussion of the problems and issues in medical care today."

House of refuge: origins of juvenile reform in New York State, 1815-1857, by Robert S. Pickett. Syracuse University Press, Box 8, University Station, Syracuse, N.Y. 13210. 1969, 217 pp., $7.50. Describes a "case study of a group of men who created an enterprise, set it in motion, and watched it grow into a national institution."

Joint and family interviews in the treatment of marital problems, by Elsbeth Herzstein Couch. Family Service Association of America, 44 E. 23d St., New York, N.Y. 10010. 1969, 330 pp., $6.50 (paper). Analyzes practitioner responses for research planning and "related theoretical and practical goals." (Data collection supported in part by the National Institute of Mental Health.)

Journal of social work process, vol. 17, Rosa Wessel, ed. University of Pennsylvania Press, 3933 Walnut Street, Philadelphia, Pa. 19104. 1969, 166 pp., $5.50. Contains articles on various aspects of social work and social work education.

Mental health consultants: agents of community change, by Charles R. Griffith and Lester M. Libo. Jossey-Bass, Inc., 615 Montgomery St., San Francisco, Calif. 94111. 1968, 206 pp., $7.75. Describes the development of a pioneering community mental health program in New Mexico.

A pilot study of intergenerational dependency in New York City: a study conducted for the Human Resources Administration of the City of New York. Greenleigh Associates, Inc., 355 Lexington Ave., New York, N.Y. 10017. 1969, 58 pp., $2. Presents the findings of a study "designed to test the method of research," not to show "cause and effect."

Planned organizational change: a study in change dynamics, by Garth N. Jones. Frederick A. Praeger, Inc., 111 4th Ave., New York, N.Y. 10003. 1969, 243 pp., $6.50. Deals with artificially assembled groups such as corporations and groups developing from an extant social or geographic base, such as community service organizations.

Public welfare in Pennsylvania, 1676-1966: a chronology, compiled by Helen W. McManus. Pennsylvania Department of Public Welfare. 1969, 75 pp., available free in single copies from the Pennsylvania Department of Public Welfare, Office of Public Relations, Health and Welfare Building, Harrisburg, Pa. 17120.

Race and the social sciences, Irwin Katz and Patricia Gurin, eds. Basic Books, 404 Park Ave. South, New York, N.Y. 10016. 1969, 400 pp., $8.95. Contains chapters on "six critical aspects of the Negro's plight" by specialists in several branches of the social sciences.

Readings in community organization practice, Ralph M. Kramer and Harry Specht, eds. Prentice-Hall, Englewood Cliffs, N.J. 07632. 1969. 458 pp., $5.95 (paper). Forty-one writers discuss the "context of community organization" and the "process of directed change."

Readings in welfare economics, selected by a committee of the American Economic Association, Kenneth J. Arrow and Tibor Scitovsky, eds. Richard D. Irwin, Inc., 1818 Ridge Rd., Homewood, Ill. 60430. 1969. 734 pp., $8.50. Discusses political aspects; social and private costs and benefits; measurement; and growth of and investment in welfare.

Rural sociology: its origin and growth in the United States, by Lowry Nelson. University of Minnesota Press, 2037 University Ave. SE, Minneapolis, Minn. 55455. Discusses the work of sociologists, particularly the early ones.

Salaries and related personnel practices of voluntary social and health agencies in New York City: September 1968, prepared by Janice Clinthorne. Research Department, Community Council of Greater New York, 225 Park Ave., South, New York, N.Y. 10003. 1969, 60 pp., $2.50.

Social services in public welfare. Public Welfare Reporting Center, National Study Service, Inc., 44 E. 23d St., New York, N.Y. 10010. 1969, 33 pp. (mimeo.), $1.75. Studies the volume and percentage of persons receiving welfare services in addition to assistance payments.

Studies in the use of health services by families on welfare: utilization by publicly-assisted families, by Richard Pomeroy with Robert Lejeune and Lawrence Podell. Research Founda-

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Publications about the Mobilization for Youth project

The following books on the Mobilization for Youth project, edited by Harold G. Weissman, were recently published by the Association Press, 291 Broadway, New York, N.Y. 10007, as volumes 1, 2, and 3 of its *New Social Work Series:*

1. Individual and group services in the Mobilization for Youth experience. 192 pp., $4.95. Describes MFY methods of offering services in the inner city.

2. Community development in the Mobilization for Youth experience. 190 pp., $2.50. Contains papers on housing, consumer affairs, voter registration, and welfare.

3. Employment and educational services in the Mobilization for Youth experience. 224 pp., $4.95. Describes MFY efforts to increase employment opportunities, employability, and the visibility of young people for employment.

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tion, City University of New York, Box 605, Lenox Hill Station, New York, N.Y. 10021. 1969, 192 pp., $2.50 for handling and mailing. Analyzes information from interviews with a "systematically random sample" of 2,179 welfare families, conducted by the National Opinion Research Center in 1966.

The uneasy equilibrium: private and public financing of health services in the United States, 1875-1965, by Odin W. Anderson. College and University Press, 263 Chapel St., New Haven, Conn. 06513. 1968, 240 pp., $5. Shows how health services developed in the U.S. political, economic, and social system.

Public Assistance Statistics

June and July 1969

June

In June 1969, 10.2 million persons received money payments under five public assistance programs—1.1 million more than in June 1968, a rise largely attributable to an increase of 949,000 recipients in the program of aid to families with dependent children (AFDC). Only 5,000 of the additional recipients were in families aided because of a parent's unemployment. Most of the others were in families in which the father was absent.

The next largest increase in number of recipients (85,000) occurred in the program of aid to the permanently and totally disabled (APTD). Increases occurred also in general assistance (GA—37,000) and old-age assistance (OAA—17,000). Only the number receiving aid to the blind (AB) decreased (1,000).

Total expenditures—Federal, State, and local—for all types of assistance in the fiscal year ended June 1969 were $1.8 billion more than in the preceding year. They amounted to $10.6 billion, including $6.1 billion in money payments, $4.4 billion in medical payments, and more than $90 million for the care of persons in intermediate care facilities. The largest increase was in AFDC—$651 million, or 25.7 percent. In APTD the increase was $93 million, or 14.9 percent; in GA, $87 million, or 23.6 percent; and in AB, $1 million, or 1.3 percent. In OAA total money payments decreased by nearly $6 million, or 0.3 percent. Expenditures for medical assistance rose by $871 million, or 24.6 percent.

Although the number of OAA recipients rose slightly in most months of the year, the total of 2,036,000 in June was less than 1 percent above that in June 1968—the first June-to-June increase, however, in 19 years. There were decreases in 31 States. The total rise for the year resulted largely from increases of 16,000 in California and 10,400 in New York. Program increases in these two populous States have significantly influenced national totals and trends in all programs.

Increases in the number of AFDC recipients during the year were relatively substantial for the Nation and for most States. The total number of recipients rose to 6,558,000, up by 16.9 percent from June 1968; the total number of children aided rose to 4,880,000, up by 16 percent. The number of recipients increased by more than 20 percent in 15 States, by 10-19.9 percent in 18 States, and by 5-9.9 percent in 12 States. California and New York each had a little over a million recipients; together, they accounted for 338,000 recipients, or a third of the year's increase.

APTD recipients numbered 755,000 in June—almost 13 percent more than a year earlier. Although 45 States reported increases, more than half the year's increase centered in California (24,000) and New York (20,000).

About 80,200 persons received AB in June 1969—down by 1.2 percent from June 1968. Nevertheless, 21 States had more recipients than in the previous year. Recipients of GA numbered 769,000, up by 37,000 from the preceding year. The year's peak in the number of GA recipients—854,000—was reached in January; decreases in each of the next 5 months reduced this figure by 85,000.

In June 1969 the average money payment per recipient was $95 in AB, $86 in APTD, $71 in OAA, $48 in GA, and $44 in AFDC. All average payments were higher in June 1969 than in June 1968, ranging from an increase of $2 per recipient of AFDC to nearly $5 in APTD.

July

In July, 10.3 million persons received money payments under public assistance programs–83,000 more than in June. Two-thirds of the increase (55,000) occurred in the program of aid to families with dependent children (AFDC), which went up in four out of every five States. Although the number of recipients in the unemployed-parent segment dropped by 18,000, the number in families in need for other reasons increased by 73,000.

General assistance (GA) showed the next largest increase (15,000)–up in about two-thirds of the States. Four large industrial States–Illinois, Michigan, Ohio, and Pennsylvania–had increases of 3,000 to 6,000; California and New York, however, reported decreases of 2,000 and 7,000. In old-age assistance (OAA) the number of recipients rose by 5,000–the fifth consecutive month to show an increase. Although three of every five States reported increases, most of those in July, as well as those in the preceding 4 months, were less than 1 percent.

In aid to the permanently and totally disabled (APTD), increases in the number of recipients in nearly four-fifths of the States resulted in a national increase of 8,000. The number of persons receiving aid to the blind (AB) changed very slightly.

Separate reporting on emergency assistance to needy families with children was initiated in July, when some 6,400 families received such aid. About three-fifths of the persons in these families and about two-fifths (34,000) of the persons in intermediate care facilities also received money payments.

Expenditures for money payments amounted to $549 million in July–$9 million more than in June. About $5.6 million of the increase occurred in AFDC. Increases were slightly more than one million in each of the other programs, except in AB, for which expenditures remained about the same.

Payments to intermediate care facilities rose by $1.9 million to $19.8 million. Emergency assistance, reported separately in July, totaled $757,000.

For the first 7 months of 1969, payments for medical care (including both payments to medical vendors and insurance premiums) came to $2.7 billion, an increase of $379 million over the same 7 months of the preceding year. About 45 percent of the 1969 expenditures were made in New York ($737 million) and California ($469 million). These two States accounted for 42 percent of the increase in the first 7 months of this year over the same 7 months a year ago.

Medical assistance under title XIX comprised almost 93 percent of total payments for medical care. Five percent of such payments were made under the other federally aided assistance programs: the remaining 2 percent represented expenditures from GA.

Virginia began a title XIX program in July, bringing to 44 the number of States and jurisdictions with such programs.

The average money payment per recipient in July remained about the same as in June in AB but rose by 40 to 70 cents in the four other programs. In AFDC the national increase of 45 cents per recipient was attributable, in part at least, to two of the 1967 amendments to title IV of the Social Security Act, which authorizes Federal grants for AFDC. These amendments made mandatory, as of July 1, 1969, certain changes which had previously been optional and were to have the effect of raising the average payment in most States. The July increase in the national average, heavily influenced by a decrease in New York,[1] fails to reflect the relatively large increases in many States. Excluding New York, the national average went up by almost one dollar.

The specified amount of change and the number of States affected were as follows:

Amount of change	*Number of States*
Decrease	14
Increase of	
Less than $1	25
$1 to $3	8
$3 to $5	4
$5 or more	3

Under the first of the Social Security amendments, States are required, as an incentive to employment, to disregard specific amounts of earnings in determining the amount of assistance a family with earnings will receive. Under the second, States must reprice the cost standards governing whether a family will receive assistance, and how much, to reflect changes in prices since the last repricing and to make appropriate adjustments in maximums and other limitations on payments. Eight States[2] also increased cost standards or made other liberalizations in their programs for adults.

[1] *A drop of almost $2 per recipient occurred from June to July in New York.*

[2] *Colorado, Hawaii, Minnesota, Mississippi, Missouri, Tennessee, Utah, and Virginia.*

June Tables

Table 1. Recent changes in public assistance: Recipients, payments, and money payments per recipient, June 1969 compared with selected earlier months

Program	Two years ago June 1967	One year ago June 1968	Last month May 1969	This month June 1969
RECIPIENTS:				
Old-Age Assistance	2,065,000	2,019,000	2,034,000	2,036,000
Aid to the Blind	83,000	81,200	79,900	80,200
Aid to the Permanently and Totally Disabled	615,000	670,000	747,000	755,000
Aid to Families with Dependent Children: Families	1,208,000	1,383,000	1,650,000	1,661,000
Persons	4,977,000	5,609,000	6,538,000	6,558,000
Children	3,744,000	4,207,000	4,864,000	4,880,000
General Assistance:				
Cases	311,000	353,000	398,000	384,000
Persons	666,000	732,000	798,000	769,000
ASSISTANCE PAYMENTS (In 000's):				
Total	$636,764	$815,718	$937,610	$936,970
Maintenance Assistance:				
Total	405,494	466,061	534,971	539,993
Old-Age Assistance	140,563	136,756	143,623	143,625
Aid to the Blind	7,255	7,388	7,580	7,643
Aid to the Permanently and Totally Disabled	47,254	54,301	63,990	64,650
Aid to Families with Dependent Children	184,577	234,676	281,891	287,420
General Assistance	25,845	32,940	37,887	36,655
Payments to intermediate care facilities	---	---	15,445	17,948
Medical Assistance:				
Total	231,270	349,657	387,194	379,029
Medical Assistance	196,066	324,609	360,686	351,267
Medical Assistance for the Aged	6,803	5,480	4,821	5,007
Other Federally Aided	23,327	14,801	15,415	16,770
General Assistance	5,074	4,767	6,272	5,986
MONEY PAYMENTS PER RECIPIENT:				
Old-Age Assistance	$68.05	$67.70	$70.60	$70.55
Aid to the Blind	87.40	91.05	94.85	95.35
Aid to the Permanently and Totally Disabled	76.90	81.10	85.65	85.65
Aid to Families with Dependent Children:				
Average per family	152.80	169.65	170.85	173.00
Average per person	37.10	41.85	43.10	43.85
General Assistance:				
Average per case	83.05	93.25	95.20	95.40
Average per person	38.80	44.95	47.50	47.65

Table 2. Amount of public assistance payments in the United States, by month, June 1968-June 1969[1]

Year and month	Total	Money payments to recipients 2/							Payments to intermediate care facilities 3/	Medical assistance 4/					
		Total	Federally aided programs					General assistance 5/		Total	Federally aided programs				
			Total	Old-age assistance	Aid to the blind	Aid to the permanently and totally disabled	Aid to families with dependent children				Total	Medical assistance (Title XIX)	Medical assistance for the aged (Title I and XVI)	Other 6/	General assistance 5/
	Amount of assistance (In thousands)														
1968															
June	$815,718	$466,061	$433,121	$136,796	$7,388	$54,301	$234,676	$32,940	---	$349,657	$344,890	$324,609	$5,480	$14,801	$4,767
July	802,207	473,443	438,206	138,160	7,411	55,125	237,510	35,237	$319	328,445	323,624	303,900	5,961	13,763	4,821
August 7/	841,629	499,573	459,891	139,306	7,437	56,146	257,002	39,682	1,236	340,820	335,782	315,866	5,381	14,535	5,038
September	821,735	478,267	440,985	138,087	7,364	55,588	239,946	37,282	1,821	341,647	336,215	316,508	5,525	14,182	5,432
October	859,071	486,903	450,659	139,327	7,396	56,696	247,240	36,244	1,985	370,183	365,226	345,064	5,678	14,484	4,957
November	862,531	484,932	449,378	138,678	7,368	56,728	246,604	35,554	2,033	375,566	370,196	349,902	5,722	14,572	5,370
December 7/	879,995	521,443	480,811	142,189	7,486	58,676	272,460	40,632	2,083	356,469	351,377	330,893	5,753	14,731	5,092
1969															
January	899,967	513,872	475,233	141,287	7,487	59,322	267,137	38,639	6,807	379,288	373,061	354,898	4,315	13,848	6,227
February	915,892	519,552	482,215	141,990	7,478	60,533	272,214	37,337	12,478	383,862	378,095	359,860	4,315	13,920	5,767
March 7/	938,607	551,297	509,656	144,628	7,625	62,339	295,064	41,641	13,283	374,027	368,412	349,087	4,525	14,800	5,615
April	944,665	535,082	496,886	143,307	7,577	62,751	283,251	38,196	14,916	394,667	388,939	369,261	4,691	14,987	5,728
May	937,610	534,971	497,084	143,623	7,580	63,990	281,891	37,887	15,445	387,194	380,922	360,686	4,821	15,415	6,272
June	936,970	539,993	503,338	143,625	7,643	64,650	287,420	36,655	17,948	379,029	373,044	351,267	5,007	16,770	5,986
	Percentage change from preceding month														
1968															
June	+2.3	+1.1	+1.2	+0.1	+0.2	+0.9	+2.0	-1.1	---	+3.9	+4.0	+4.3	-3.4	+1.4	-5.6
July	-1.7	+1.6	+1.1	+.8	+.3	+1.5	+1.2	+6.9	---	-6.1	-6.2	-6.4	+8.8	-7.0	+1.1
August 7/	+2.5	+1.4	+1.0	(8/)	-.3	+.7	+1.7	+3.1	+287.7	+3.8	+3.8	+3.9	-9.7	+5.6	+4.5
September	+.1	-.2	-.4	-.1	-.3	+.1	-.7	+2.8	+47.3	+.2	+.1	+.2	+2.7	-2.4	+7.8
October	+4.5	+1.8	+2.2	+.9	+.4	+2.0	+3.0	-2.8	+9.0	+8.4	+8.6	+9.0	+2.8	+2.1	-8.7
November	+.4	-.4	-.3	-.5	-.4	+.1	-.3	-1.9	+2.4	+1.5	+1.4	+1.4	+.8	+.6	+6.2
December 7/	-.5	+3.0	+2.9	+1.7	+1.0	+2.3	+3.5	+4.1	+2.5	-4.3	-4.3	-4.6	+.5	+1.1	-7.2
1969															
January	+2.4	+3.6	+2.8	+.1	+.7	+2.2	+4.2	+3.9	+226.8	+6.4	+6.2	+7.3	-25.0	-6.0	+22.2
February	+1.7	+1.1	+1.5	+.5	-.1	+2.0	+1.9	-3.4	+83.3	+1.2	+1.1	+1.1	0	+.5	-7.4
March 7/	(9/)	+1.7	+1.9	+1.0	+1.3	+1.7	+2.1	+2.1	+6.5	-2.6	-2.6	-3.0	+6.3	+6.3	-2.6
April	+3.2	+1.2	+1.3	-.1	-.6	+1.9	+2.0	+.1	+12.3	+5.5	+5.6	+5.8	+3.7	+1.3	+2.0
May	-.7	(9/)	(8/)	+.2	(8/)	+2.0	-.5	-.8	+3.5	-1.9	-2.1	-2.3	+2.8	+5.5	+9.5
June	-.1	+.9	+1.3	(8/)	+.8	+1.0	+2.0	-3.3	+16.2	-2.1	-2.1	-2.6	+3.9	+8.8	-4.6
	Percentage change from same month of preceding year														
1969 June	+14.9	+15.9	+16.2	+5.0	+3.4	+19.1	+22.5	+11.3	---	+8.4	+8.2	+8.2	-8.6	+13.3	+25.6

1/ All data subject to revision.
2/ Includes nonmedical vendor payments other than those for institutional services in intermediate care facilities.
3/ Data represent payments to vendors of institutional services in intermediate care facilities. Federal financial participation in such payments is limited to those in behalf of individuals who qualify for OAA, AB, or APTD under programs operated under State plans approved under titles I, X, XIV or XVI.
4/ Amounts represent primarily bills paid to medical vendors during the month and therefore are subject to fluctuations unrelated to provisions of medical services.
5/ Partly estimated. Does not include Idaho, Indiana, Kentucky, Nebraska, Nevada and Puerto Rico; data not available.
6/ Data represent payments to medical vendors under maintenance assistance programs operated under State plans approved under titles I, IV, X, XIV, or XVI.
7/ Amounts for money payments include a special grant of $25.00 per person (aggregating $20,500,000 in August, $22,002,000 in December and $22,807,000 in March) issued quarterly in New York City. Percentage changes based on data excluding these amounts.
8/ Increase of less than 0.05 percent.
9/ Decrease of less than 0.05 percent.

Note: Beginning with the March 1969 release, the total in column 2 is the sum of the money payment columns; previously it also included payments to intermediate care facilities.

Note: Beginning with the March 1969 release, the total in column 2 is the sum of the money payment columns; previously it also included payments to [illegible]

Table 3. Number of recipients of public assistance maintenance payments in the United States, by month, June 1968-June 1969[1]

Year and month	Recipients of money payments 2/										Recipients of institutional services in intermediate care facilities 3/
	Total	Federally aided programs							General assistance 4/		
		Total	Old-age assistance	Aid to the blind	Aid to the permanently and totally disabled	Aid to families with dependent children			Cases	Recipients	
						Families	Total recipients 5/	Children			
	Number of recipients (In thousands)										
1968											
June	9,111	8,379	2,019	81.2	670	1,383	5,609	4,207	353	732	---
July	9,178	8,410	2,019	81.0	674	1,397	5,636	4,229	367	768	2.6
August	9,274	8,490	2,022	81.0	680	1,420	5,707	4,275	375	784	7.6
September	9,425	8,588	2,021	81.0	684	1,444	5,802	4,351	383	837	12.3
October	9,480	8,680	2,025	81.0	691	1,471	5,883	4,409	382	800	12.7
November	9,561	8,763	2,026	81.0	696	1,490	5,960	4,465	382	798	13.0
December	9,723	8,896	2,027	80.7	702	1,522	6,086	4,555	392	827	13.6
1969											
January	9,892	9,038	2,025	80.5	711	1,556	6,221	4,650	404	854	6/ 23.4
February	10,027	9,199	2,025	80.3	718	1,591	6,376	4,743	402	828	58.2
March	10,143	9,316	2,030	80.4	728	1,621	6,478	4,815	404	827	60.4
April	10,193	9,367	2,031	80.2	738	1,641	6,538	4,860	397	806	66.6
May	10,197	9,399	2,034	79.9	747	1,650	6,538	4,864	398	798	68.8
June	10,198	9,429	2,036	80.2	755	1,661	6,558	4,880	384	769	76.4
	Percentage change from preceding month										
1968											
June	-0.3	-0.1	-0.2	0	+0.6	+0.2	-0.1	(7/)	-0.8	-2.3	---
July	+.7	+.4	0	-.2	+.6	+1.0	+.4	+.5	+3.8	+4.9	---
August	+1.0	+1.0	+.1	0	+.9	+1.6	+1.2	+1.1	+2.2	+2.1	+194.6
September	+1.6	+1.2	(7/)	0	+.6	+1.7	+1.7	+1.8	+2.1	+6.8	+61.3
October	+.6	+1.1	+.2	0	+1.0	+1.9	+1.4	+1.3	-.3	-4.4	+3.4
November	+.9	+1.0	(8/)	0	+.7	+1.3	+1.3	+1.3	0	-.2	+2.4
December	+1.7	+1.5	(8/)	-.4	+.9	+2.0	+2.1	+2.0	+2.6	+3.6	+4.8
1969											
January	+1.7	+1.6	-.1	-.3	+1.3	+2.2	+2.2	+2.1	+3.1	+2.7	+71.8
February	+1.4	+1.8	0	-.3	+1.1	+2.3	+2.5	+2.0	-.4	-3.0	+149.0
March	+1.2	+1.3	+.2	+.1	+1.3	+1.9	+1.6	+1.5	+.3	-.2	+3.8
April	+.5	+.8	+.1	-.2	+1.4	+1.2	+.9	+.9	-1.6	-2.5	+10.3
May	(8/)	+.1	+.1	-.4	+1.3	+.5	0	+.1	+.3	-1.0	+3.3
June	(8/)	+.3	+.1	+.3	+1.0	+.7	+.3	+.3	-3.4	-3.6	+11.0
	Percentage change from same month of preceding year										
1969											
June	+11.9	+12.5	+.8	-1.2	+12.7	+20.1	+16.9	+16.0	+8.8	+5.0	---

1/ All data subject to revision.
2/ Includes recipients of nonmedical vendor payments other than those for institutional services in intermediate care facilities.
3/ Includes recipients of OAA, AB, or APTD for whom such payments are subject to Federal financial participation under approved State plans under titles I, X, XIV, or XVI and a few AFDC or GA recipients for whom such payments are made without Federal participation.
4/ Partly estimated. Does not include Idaho, Indiana, Kentucky, Nebraska, Nevada, and Puerto Rico; data not available.
5/ Includes as recipients the children and 1 or both parents or 1 caretaker relative other than a parent in families in which the requirements of such adults were considered in determining the amount of assistance.
6/ Does not include Illinois; data not available.
7/ Decrease of less than 0.05 percent.
8/ Increase of less than 0.05 percent.

Note: Beginning with the March 1969 release, the total in Column 1 includes all recipients of money payments; previously it did not include recipients of general assistance. Column 2 is the total for all Federally aided programs; previously it included only the adult programs.

Table 4. Old-age assistance: Recipients of money payments and amount of payments, by State, June 1969[1]

[Excludes vendor payments for institutional services in intermediate care facilities and for medical care and recipients of only such payments]

State	Number of recipients	Payments to recipients		Percentage change from--			
		Total amount	Average	May 1969 in--		June 1968 in--	
				Number	Amount	Number	Amount
Total 2/	2,036,000	$143,625,000	$70.55	+0.1	(3/)	+0.8	+5.0
Ala.	114,000	7,059,000	61.90	(3/)	(4/)	+1.4	+5.7
Alaska 5/	1,500	134,000	89.30	-.4	+.2	+3.1	+14.8
Ariz.	11,800	653,000	55.50	+.1	-.2	-8.6	+.5
Ark. 5/	60,700	3,251,000	53.60	+.2	-.2	-2.2	-4.3
Calif.	308,000	32,679,000	106.00	+.4	+.7	+5.6	+12.1
Colo. 2/	38,000	2,972,000	78.10	-.2	-.6	-2.4	-1.7
Conn.	7,700	695,000	90.65	+.3	+3.2	+11.5	+39.9
Del.	1,800	107,000	58.20	-.8	-1.0	-.3	-7.6
D. C.	2,400	182,000	75.60	+.2	(4/)	+7.3	+8.2
Fla. 5/	69,400	3,389,000	48.80	+.7	+.6	-1.9	+2.0
Ga. 5/	90,700	4,608,000	50.80	+.4	+.3	+2.5	+.3
Guam	290	15,000	51.30	+2.1	+1.7	+21.1	+19.4
Hawaii 5/	2,000	179,000	90.00	+.5	+.4	+7.3	+17.9
Idaho	3,200	211,000	64.95	-.4	-.1	-6.8	-5.2
Ill. 5/	37,500	2,417,000	64.50	+.2	-4.9	-1.1	+6.0
Ind.	16,900	794,000	46.95	(3/)	+.1	-4.5	-3.9
Iowa	23,400	2,525,000	107.80	-.3	-.1	-.6	+5.6
Kans. 5/	14,200	1,116,000	78.35	+.3	+.6	-12.3	-21.5
Ky. 5/	64,200	3,446,000	53.65	+.4	+.4	+5.6	+5.9
La.	120,000	8,319,000	69.30	-.2	-.3	-1.8	-2.6
Maine 5/	10,200	609,000	59.80	+.6	+1.0	+.9	+12.3
Md. 5/	8,600	642,000	74.25	+.3	+1.5	+12.2	+39.0
Mass.	49,600	4,445,000	89.60	-.2	+1.9	+3.3	+15.1
Mich.	37,500	2,706,000	72.25	+.1	+.2	-1.4	+6.2
Minn.	22,300	1,467,000	65.70	-.5	-.1	-7.4	-2.9
Miss.	71,900	2,831,000	39.40	-.1	-.3	+.7	+10.1
Mo.	90,100	6,502,000	72.20	(3/)	+.1	-1.9	+4.4
Mont.	3,600	228,000	63.30	+.6	+.9	-2.4	-3.4
Nebr. 5/	8,000	459,000	57.65	-.2	-.1	-4.6	-3.2
Nev.	3,000	206,000	68.65	+2.8	+4.3	+17.5	+8.0
N. H.	4,200	485,000	116.25	+.5	+.7	+1.2	+9.3
N. J.	14,700	1,174,000	79.70	+.7	+.8	+5.1	+15.3
N. Mex. 5/	9,200	510,000	55.60	-3.9	-.5	-4.0	-1.5
N. Y. 5/	86,500	7,769,000	89.85	+.8	-4.3	+13.6	+10.3
N. C. 5/	38,100	2,696,000	70.85	+.5	+.8	+1.9	+9.8
N. Dak. 5/	3,900	305,000	78.35	-.8	-.1	-5.1	-.7
Ohio	58,800	3,496,000	59.45	-1.3	-1.6	-4.4	-6.6
Okla. 5/	75,300	5,273,000	70.00	+.2	-.2	-2.8	-5.1
Oreg.	7,200	456,000	63.10	+.5	+.5	-17.9	-10.2
Pa.	44,900	3,760,000	83.70	+.2	+1.3	+5.0	+24.6
P. R. 5/	21,200	265,000	12.50	-1.0	-.1	-3.5	-40.3
R. I. 5/	3,700	184,000	49.75	-18.6	+.7	-10.7	-24.8
S. C.	19,000	855,000	45.10	-.3	-.2	-5.7	-8.3
S. Dak.	4,600	283,000	61.50	-.4	(3/)	-6.9	-7.2
Tenn.	49,800	2,542,000	51.05	+.6	+3.2	-.7	+2.8
Tex.	228,000	13,512,000	59.25	+.3	+1.0	-.5	-2.1
Utah 6/	4,300	192,000	44.25	---	---	---	---
Vt. 5/	4,300	307,000	71.55	+.3	+1.0	+.6	+5.9
V. I.	370	14,100	38.20	-.5	-.7	-.3	-1.5
Va.	11,200	739,000	66.15	+1.2	+4.5	+3.0	+22.0
Wash.	22,900	1,440,000	62.80	-.3	-1.1	-5.5	-4.8
W. Va.	11,200	748,000	66.85	+.4	+.5	-.9	+7.6
Wis.	18,200	1,614,000	88.45	+.2	-7.4	+12.0	+59.1
Wyo.	2,000	159,000	80.60	-.9	+.2	-4.9	-1.7

1/ All data subject to revision. Data include nonmedical vendor payments other than those for institutional services in intermediate care facilities.
2/ Includes 3,600 recipients aged 60-64 in Colorado and payments of $327,000 to these recipients. Such payments were made without Federal participation.
3/ Increase of less than 0.05 percent.
4/ Decrease of less than 0.05 percent.
5/ Represents aid to the aged under program for aid to the aged, blind, or disabled, or for such aid and medical assistance for the aged.
6/ Represents data for May; June data not reported.

Table 5. Aid to the blind: Recipients of money payments and amount of payments, by State, June 1969[1]

[Excludes vendor payments for institutional services in intermediate care facilities and for medical care and recipients of only such payments]

State	Number of recipients	Payments to recipients		Percentage change from--			
		Total amount	Average	May 1969 in--		June 1968 in--	
				Number	Amount	Number	Amount
Total 2/ 3/	80,200	$7,643,000	$95.35	+0.3	+0.8	-1.2	+3.4
Ala.	1,900	136,000	70.20	+.7	+.7	+3.5	+3.6
Alaska 4/	95	11,400	120.00	(5/)	(5/)	(5/)	(5/)
Ariz.	560	41,100	73.35	-1.2	-1.4	-14.1	-10.3
Ark. 4/	1,800	122,000	67.45	+.2	+.2	-2.2	-4.9
Calif. 2/	12,900	1,892,000	146.40	+.5	+.6	+3.2	+9.3
Colo.	200	16,100	81.15	-1.5	+4.8	-2.9	+9.3
Conn.	240	21,900	93.15	-1.7	-7.2	-3.7	+9.0
Del.	360	32,000	88.95	+1.1	+1.7	+5.3	+2.5
D. C.	190	16,600	85.75	0	+1.4	+6.0	+1.5
Fla. 4/	2,300	150,000	64.00	+.1	+.2	-3.6	-1.3
Ga. 4/	3,200	200,000	62.25	+.4	+.5	+1.8	+.8
Guam	7	440	(5/)	(5/)	(5/)	(5/)	(5/)
Hawaii 4/	66	7,100	108.10	(5/)	(5/)	(5/)	(5/)
Idaho	110	8,500	78.85	+.9	+.3	+4.9	+7.7
Ill. 4/	1,700	149,000	86.70	-.2	-1.8	-3.7	+4.0
Ind.	1,500	90,600	61.85	+4.0	-.3	+1.6	-3.4
Iowa	1,000	118,000	112.50	+.4	+1.3	-.1	+5.9
Kans. 4/	370	30,500	82.30	+.5	+2.7	-6.1	-13.4
Ky. 4/	2,100	149,000	69.60	-.6	-1.4	-17.8	-18.8
La.	2,400	186,000	76.60	+.2	+1.1	-2.3	-2.9
Maine 4/	220	18,100	84.25	0	+2.3	+1.4	+13.7
Md. 4/	340	29,700	88.45	-.6	-.4	-2.9	+4.7
Mass.	2,600	378,000	148.05	+.4	-1.8	+3.5	+23.7
Mich.	1,400	131,000	94.10	+.1	+.3	-3.0	+3.9
Minn.	800	64,700	80.60	-.7	-.5	-.1	+.4
Miss.	2,200	109,000	49.55	-.4	+.4	-5.3	+3.6
Mo. 2/	3,800	333,000	86.65	+.1	-.4	-1.3	-1.5
Mont.	160	13,100	80.30	+.6	+1.7	+3.8	+4.9
Nebr. 4/	340	29,400	85.30	-.9	-4.4	-2.5	-1.7
Nev.	180	15,800	90.00	-1.1	-.4	+15.8	+3.7
N. H.	230	27,200	116.65	-1.3	-1.5	-1.3	+6.0
N. J.	910	89,800	98.90	+1.0	+.7	+2.6	+15.6
N. Mex. 4/	370	27,700	75.00	0	+2.6	-.3	-.5
N. Y. 4/	3,500	419,000	120.45	+.3	+2.8	+7.5	+7.7
N. C. 4/	4,700	422,000	90.55	+.5	+8.8	+.8	+15.8
N. Dak. 4/	84	8,200	97.50	(5/)	(5/)	(5/)	(5/)
Ohio	2,700	200,000	72.95	-.7	-.1	-3.6	-3.3
Okla. 4/	1,400	139,000	102.60	-.4	-.6	-9.5	-11.0
Oreg.	470	44,100	93.35	+2.4	+.3	-6.2	-2.1
Pa. 3/	8,900	978,000	110.30	-.3	+.1	+4.8	-2.3
P. R. 4/	760	9,500	12.50	-.8	-.8	-5.6	-41.3
R. I. 4/	120	8,200	70.40	-.8	+2.1	+1.7	+.3
S. C.	1,900	109,000	57.95	+.2	(6/)	-.3	-2.1
S. Dak.	110	9,600	84.45	-.9	-1.8	+1.8	+.3
Tenn.	1,800	119,000	66.70	-.3	+.4	-.7	-1.7
Tex.	4,100	295,000	72.15	+2.9	+3.2	-2.6	-3.3
Utah 7/	140	8,700	60.15	---	---	---	---
Vt. 4/	100	9,400	89.65	-.9	-.1	0	+4.3
V. I.	7	290	(5/)	(5/)	(5/)	(5/)	(5/)
Va.	1,100	86,600	81.65	-.1	+4.4	-2.0	+8.3
Wash.	460	40,300	87.40	-.2	-1.1	-4.2	-4.1
W. Va.	570	34,100	60.10	-.5	+.3	-5.8	+.1
Wis.	650	56,100	86.35	+2.4	+1.2	+13.2	+24.2
Wyo.	41	3,200	(5/)	(5/)	(5/)	(5/)	(5/)

1/ All data subject to revision. Data include nonmedical vendor payments other than those for institutional services in intermediate care facilities.
2/ Data include recipients of payments made without Federal participation and payments to these recipients as follows: California, $40,100 to 230 recipients and Missouri, $44,600 to 510 recipients.
3/ Does not include $595,000 to an estimated 7,800 recipients under State blind pension program in Pennsylvania administered under State Law without Federal participation.
4/ Represents aid to the blind under program for aid to the aged, blind, or disabled, or for such aid and medical assistance for the aged.
5/ Average payment not computed on base of fewer than 50 recipients; percentage change on fewer than 100 recipients.
6/ Decrease of less than 0.05 percent.
7/ Represents data for May; June data not reported.

Table 6. Aid to the permanently and totally disabled: Recipients of money payments and amount of payments, by State, June 1969[1]

[Excludes vendor payments for institutional services in intermediate care facilities and for medical care and recipients of only such payments]

State	Number of recipients	Payments to recipients		Percentage change from--			
		Total amount	Average	May 1969 in--		June 1968 in--	
				Number	Amount	Number	Amount
Total.....	755,000	$64,650,000	$85.65	+1.0	+1.0	+12.7	+19.1
Ala.....	17,000	848,000	50.00	+.6	+.5	+7.8	+8.5
Alaska 2/.....	620	70,500	114.30	+.5	+.7	+33.8	+50.3
Ariz.....	6,200	407,000	65.35	+.6	+.5	+2.3	+1.8
Ark. 2/.....	11,200	679,000	60.55	+.4	+.1	-1.8	-3.5
Calif.....	149,000	18,285,000	123.00	+1.5	+1.5	+19.2	+24.7
Colo.....	7,600	558,000	73.10	+1.5	+1.9	+6.6	+16.0
Conn.....	6,000	683,000	113.50	+1.4	+7.2	+22.8	+50.3
Del.....	1,300	124,000	96.35	+1.1	+1.8	+17.6	+23.9
D. C.....	4,800	427,000	88.60	+1.9	+2.4	+13.8	+12.6
Fla. 2/.....	20,400	1,254,000	61.35	+.5	+.8	+.4	+3.6
Ga. 2/.....	31,000	1,876,000	60.60	+.6	+.6	+5.2	+3.9
Guam.....	49	2,700	(3/)	(3/)	(3/)	(3/)	(3/)
Hawaii 2/.....	1,600	202,000	123.55	-.3	+.7	+4.8	+19.2
Idaho.....	2,800	216,000	76.05	+.5	+1.2	+5.2	+7.1
Ill. 2/.....	36,800	3,198,000	86.80	+.9	-2.1	+10.5	+16.8
Ind.....	4,400	226,000	51.50	+3.2	+3.6	+41.0	+43.4
Iowa.....	2,700	357,000	133.75	-.6	+.2	+13.2	+18.3
Kans. 2/.....	5,600	529,000	94.35	+.9	+.8	+.6	-18.9
Ky. 2/.....	15,000	1,046,000	69.95	+.2	+.3	-2.1	-3.1
La.....	22,000	1,179,000	53.50	-.3	-.3	-1.2	-1.2
Maine 2/.....	3,200	272,000	85.35	+2.5	+2.6	+17.9	+32.3
Md. 2/.....	14,900	1,250,000	84.10	+1.2	+2.4	+12.2	+20.7
Mass.....	15,400	1,647,000	106.90	-2.1	(4/)	+3.4	+16.5
Mich.....	22,900	2,145,000	93.85	+1.6	+1.2	+16.9	+26.1
Minn.....	9,000	800,000	88.65	+.9	+4.1	+8.1	+20.3
Miss.....	21,500	1,050,000	48.75	-.3	-.5	-1.1	+8.3
Mo.....	18,100	1,338,000	74.05	+.4	+.6	+4.9	+5.7
Mont.....	1,800	143,000	77.60	+1.5	+2.6	+17.7	+18.1
Nebr. 2/.....	3,700	246,000	67.00	+3.4	-.4	+7.5	+2.6
N. H.....	750	78,200	103.70	-.4	-.5	+8.3	+12.9
N. J.....	11,300	1,157,000	102.20	+1.4	-.6	+14.7	+31.0
N. Mex. 2/.....	7,100	499,000	70.15	-.7	+.9	+20.9	+22.7
N. Y. 2/.....	62,000	6,437,000	103.85	+3.1	+1.9	+46.3	+43.8
N. C. 2/.....	25,200	1,888,000	74.80	+.7	+.7	+8.1	+14.5
N. Dak. 2/.....	2,000	175,000	87.90	-.1	+1.0	+7.0	+9.5
Ohio.....	28,700	2,070,000	72.15	+.4	+.4	+17.1	+17.1
Okla. 2/.....	19,700	1,836,000	93.40	+.9	+.8	+1.0	-.3
Oreg.....	4,800	420,000	88.25	+.1	+.8	-7.8	+3.7
Pa.....	26,500	2,371,000	89.60	-.5	+1.2	+2.3	+25.6
P. R. 2/.....	13,400	168,000	12.55	+2.0	+.9	+7.2	-34.1
R. I. 2/.....	3,600	278,000	77.55	-2.4	+1.7	+2.8	-2.8
S. C.....	9,700	498,000	51.60	+.7	+.7	+4.5	+2.2
S. Dak.....	1,400	91,700	65.05	+.9	+1.5	+7.4	+4.0
Tenn.....	21,000	1,369,000	65.20	+.9	+.8	+13.1	+12.6
Tex.....	20,300	1,205,000	59.20	+3.3	+3.0	+30.4	+37.1
Utah 5/.....	5,200	316,000	60.95	---	---	---	---
Vt. 2/.....	1,700	155,000	89.30	-.2	+.8	+16.4	+26.5
V. I.....	69	2,800	40.30	(3/)	(3/)	(3/)	(3/)
Va.....	7,300	581,000	79.15	+.9	+4.9	+3.2	+22.1
Wash.....	12,900	1,074,000	83.35	+1.8	+1.5	+24.7	+30.9
W. Va.....	6,700	376,000	56.50	+.8	+1.1	+7.8	+10.7
Wis.....	6,600	486,000	74.15	+.3	-7.7	+16.4	+38.8
Wyo.....	820	59,800	73.40	-3.4	-3.2	-2.4	+.9

1/ All data subject to revision. Data include nonmedical vendor payments other than those for institutional services in intermediate care facilities.
2/ Represents aid to the permanently and totally disabled under program for aid to the aged, blind, or disabled, or for such aid and medical assistance for the aged.
3/ Average payment not computed on base of fewer than 50 recipients; percentage change on fewer than 100 recipients.
4/ Increase of less than 0.05 percent.
5/ Represents data for May; June data not reported.

Table 7. Aid to families with dependent children: Recipients of money payments and amount of payments, by State, June 1969[1]

/Excludes vendor payments for institutional services in intermediate care facilities and for medical care and cases receiving only such payments/

State	Number of families	Number of recipients		Payments to recipients			Percentage change from--			
					Average per--		May 1969 in--		June 1968 in--	
		Total 2/	Children	Total amount	Family	Recipient	Number of recipients	Amount	Number of recipients	Amount
Total 3/...	1,661,000	6,558,000	4,880,000	$287,420,000	$173.00	$43.85	+0.3	+2.0	+16.9	+22.5
Ala.....	25,700	105,000	83,900	1,647,000	64.05	15.60	-.1	+.8	+16.6	+20.4
Alaska.....	2,000	7,000	5,300	333,000	165.75	47.85	+.8	+1.0	+20.5	+51.3
Ariz.....	10,700	45,400	34,500	1,298,000	121.45	28.60	+2.0	+2.6	+4.3	+3.5
Ark.....	10,200	40,700	30,900	797,000	78.25	19.60	+.6	+.4	+4.4	+6.2
Calif. 3/.....	267,000	1,004,000	721,000	50,066,000	186.25	49.85	-.1	+2.0	+22.8	+34.4
Colo. 3/.....	15,500	57,200	43,400	2,261,000	145.60	39.55	(4/)	+.2	+5.1	+4.5
Conn. 3/.....	20,600	78,300	58,300	4,707,000	228.65	60.10	+.8	-1.2	+19.3	+37.8
Del. 3/.....	4,700	18,100	13,700	597,000	129.30	32.95	(4/)	+.3	+5.6	+8.0
D. C.....	7,700	33,000	26,100	1,379,000	179.75	41.85	+.8	+1.4	+24.6	+34.1
Fla.....	45,600	178,000	141,000	3,715,000	81.50	20.85	+1.2	+2.7	+19.2	+64.2
Ga.....	41,800	161,000	123,000	3,950,000	94.40	24.55	+1.8	+1.8	+39.7	+37.6
Guam.....	310	1,500	1,300	51,400	167.40	33.65	+3.7	+2.1	+32.9	+29.0
Hawaii 3/.....	5,300	21,400	15,600	1,022,000	192.55	47.80	+1.0	-.5	+8.5	+16.9
Idaho.....	3,500	13,000	9,300	618,000	177.30	47.70	+1.5	+1.0	+6.5	+8.7
Ill. 3/.....	77,400	337,000	262,000	16,046,000	207.20	47.60	+.3	-1.8	+14.2	+23.7
Ind.....	14,600	60,100	45,200	1,929,000	132.05	32.10	+1.2	+.9	+12.9	+11.2
Iowa.....	16,300	58,600	42,600	2,980,000	195.20	50.90	-1.0	+1.3	+12.4	+16.1
Kans. 3/.....	11,800	46,900	36,200	2,214,000	188.30	47.20	+1.0	+1.0	+14.3	+22.7
Ky.....	32,000	123,000	88,900	3,598,000	112.50	29.25	+.5	+.7	+12.8	+15.8
La.....	41,400	178,000	138,000	4,289,000	103.70	24.10	+1.7	+1.7	+26.4	+28.8
Maine 3/.....	8,000	29,300	21,700	953,000	118.45	32.55	+2.1	+10.8	+31.0	+43.7
Md. 3/.....	30,500	118,000	90,900	4,616,000	151.45	39.15	-.1	-.4	+6.1	+6.6
Mass. 3/.....	49,500	181,000	133,000	11,515,000	232.70	63.60	+.3	-3.9	+21.5	+38.4
Mich. 3/.....	54,100	217,000	163,000	10,289,000	190.05	47.50	+1.1	-.7	+10.1	+15.8
Minn.....	18,600	66,100	50,800	3,713,000	200.05	56.15	+.3	+1.0	+7.3	+11.6
Miss.....	26,700	106,000	87,100	1,080,000	40.45	10.20	(4/)	+1.7	+3.5	+24.2
Mo. 3/.....	30,800	124,000	95,300	3,331,000	108.25	26.75	+.3	+.4	+7.1	+16.3
Mont.....	3,100	11,400	8,700	429,000	138.40	37.50	+.5	+1.3	+15.3	+17.0
Nebr. 3/.....	6,900	26,500	20,400	999,000	145.45	37.65	-.1	-.2	+8.4	+10.8
Nev.....	2,800	9,400	7,200	306,000	110.95	32.40	+2.9	+6.1	+10.2	+15.7
N. H.....	1,900	7,700	5,700	340,000	177.50	44.00	+2.9	+2.6	+24.8	+26.6
N. J. 3/.....	55,000	221,000	164,000	14,648,000	266.50	66.40	+2.4	+1.9	+39.0	+58.5
N. Mex.....	11,500	44,800	34,100	1,403,000	121.80	31.30	-.2	+1.7	+8.4	+10.0
N. Y. 3/.....	260,000	1,005,000	724,000	66,003,000	254.10	65.65	-.3	+6.3	+17.9	+7.8
N. C.....	28,800	115,000	86,500	3,273,000	113.65	28.55	+.3	+1.0	+6.9	+18.1
N. Dak.....	2,700	10,100	7,700	505,000	190.45	50.00	-1.9	-.2	+2.4	+6.9
Ohio 3/.....	61,900	248,000	185,000	9,814,000	158.50	39.60	-.6	-.8	+7.5	+13.5
Okla. 3/.....	23,600	88,800	66,700	3,034,000	128.35	34.15	-1.7	-1.7	+.1	-.6
Oreg. 3/.....	14,100	52,000	36,900	2,236,000	158.10	43.05	+2.5	+.7	+31.4	+40.4
Pa. 3/.....	92,200	376,000	273,000	19,580,000	212.30	52.05	+.9	+4.4	+23.0	+66.1
P. R.....	39,700	197,000	148,000	1,595,000	40.25	8.10	+.4	-3.0	+13.4	-42.9
R. I. 3/.....	9,200	35,300	25,600	1,692,000	183.60	48.00	-.1	-3.6	+13.6	+14.2
S. C.....	10,900	42,200	33,700	780,000	71.65	18.50	+1.6	+1.9	+36.7	+37.0
S. Dak.....	4,000	15,000	11,200	687,000	169.65	45.90	+1.1	+2.0	+8.1	+11.6
Tenn.....	29,300	114,000	87,500	2,983,000	101.65	26.25	+.3	+.4	+13.4	+12.4
Tex.....	36,900	166,000	127,000	2,811,000	76.20	16.95	+2.8	+3.5	+18.0	-2.2
Utah 3/ 5/....	7,900	29,700	20,700	1,128,000	142.95	37.95	---	---	---	---
Vt. 3/.....	3,100	11,500	8,300	573,000	182.75	49.95	-.3	+1.3	+24.5	+33.0
V. I.....	420	1,700	1,400	48,100	115.30	28.40	+2.2	+1.8	+4.3	+3.0
Va.....	17,700	71,100	54,700	2,732,000	154.20	38.45	+1.7	+3.3	+17.3	+45.8
Wash. 3/.....	22,600	79,700	56,600	3,844,000	169.75	48.20	+.6	-2.5	+21.9	+23.3
W. Va. 3/.....	19,400	83,200	57,800	2,185,000	112.85	26.25	-8.8	-6.5	-5.6	-3.1
Wis. 3/.....	21,800	82,600	62,100	4,624,000	212.15	55.95	+.5	+1.4	+18.7	+32.1
Wyo.....	1,200	4,500	3,500	171,000	140.85	38.00	-8.9	-6.2	-1.6	-1.8

1/ All data subject to revision. Data include nonmedical vendor payments other than those for institutional services in intermediate care facilities.
2/ Includes as recipients the children and 1 or both parents or 1 caretaker relative other than a parent in families in which the requirements of such adults were considered in determining the amount of assistance.
3/ Includes data on unemployed-parent segment; see table 8.
4/ Increase of less than 0.05 percent.
5/ Represents data for May; June data not reported.

Table 8. Aid to families with dependent children, unemployed-parent segment: Receipts of money payments and amount of payments, by State, June 1969[1]

/Excludes vendor payments for institutional services in intermediate care facilities and for medical care and cases receiving only such payments/

State	Number of families	Number of recipients		Payments to recipients			Percentage change from--			
					Average per--		May 1969 in--		June 1968 in--	
		Total 2/	Children	Total	Family	Recipient	Number of recipients	Amount	Number of recipients	Amount
Total.....	64,700	353,000	230,000	$15,856,000	$245.25	$44.85	-8.8	-6.7	+1.7	+10.1
Calif.....	26,500	141,000	91,000	5,916,000	223.05	42.05	-9.2	-7.7	+10.2	+24.7
Colo.....	960	4,800	3,200	200,000	207.40	41.90	-6.4	-5.4	-5.4	-3.7
Conn.....	180	1,000	680	56,500	312.05	55.80	-13.1	-13.1	-42.3	-35.5
Del.....	52	370	270	10,200	196.20	27.55	+2.2	-1.3	-62.4	-66.9
Hawaii.....	220	1,300	880	59,500	264.50	44.80	-5.4	-9.8	-39.8	-35.4
Ill.....	3,200	19,500	13,200	871,000	271.20	44.65	-4.3	-5.2	-7.1	+1.3
Kans.....	210	1,300	850	57,700	269.85	45.85	+.0	+6.8	-26.5	-11.2
Maine.....	37	230	160	6,900	(3/)	29.85	+7.9	+7.7	(4/)	(4/)
Md.....	160	900	570	32,000	202.80	35.70	+2.9	+1.6	-19.7	-18.9
Mass.....	780	4,400	2,900	246,000	316.50	56.45	-3.7	-3.2	+13.9	22.4
Mich.....	1,300	7,800	5,200	328,000	253.55	42.05	-3.6	-4.6	-31.6	-28.2
Mo.....	91	590	400	16,400	180.70	28.05	-12.3	-12.1	(5/)	(5/)
Nebr.....	59	370	300	12,100	204.50	32.25	-9.0	-10.8	-37.0	-40.2
N. J.....	2,900	16,700	11,100	1,191,000	407.40	71.40	+6.2	+7.6	(5/)	(5/)
N. Y.....	14,400	78,500	50,300	4,072,000	282.80	51.85	-6.9	-6.5	-.6	-13.8
Ohio.....	2,000	11,700	7,800	447,000	229.00	38.30	-10.7	-14.1	-33.1	-27.8
Okla.....	380	2,200	1,500	80,200	213.95	35.85	-6.7	-8.4	-33.6	-28.0
Oreg.....	1,700	9,000	5,700	349,000	207.90	38.80	-5.6	-8.0	+56.2	+55.7
Pa.....	2,300	13,000	8,500	576,000	247.95	44.15	-11.7	-7.4	-22.4	+15.9
R. I.....	300	1,700	1,100	65,100	215.70	38.20	-3.2	-8.7	-22.2	-24.9
Utah 6/.....	970	5,300	3,400	185,000	191.80	35.10	---	---	---	---
Vt.....	62	380	250	17,600	283.10	46.70	-31.5	-33.5	(5/)	(5/)
Wash.....	800	3,700	2,200	162,000	203.05	44.35	-14.9	-18.8	+53.6	+66.2
W. Va.....	4,200	22,900	14,700	631,000	151.75	27.60	-26.3	-18.0	-29.6	-25.8
Wis.....	930	5,200	3,400	267,000	286.20	51.15	-3.1	-2.3	+7.8	+26.9

1/ Data for this segment of the program, shown separately here, are included in data for the total program. All data subject to revision. Data include nonmedical vendor payments other than those for institutional services in intermediate care facilities.
2/ Includes as recipients the children and 1 or both parents or 1 caretaker relative other than a parent in families in which the requirements of such adults were considered in determining the amount of assistance.
3/ Average payment not computed on base of fewer than 50 families; percentage change on fewer than 100 recipients.
4/ Program not in operation in June 1968.
5/ First payment under this program made by Missouri in August 1968; by Vermont in July 1968; by New Jersey in January 1969.
6/ Represents data for May; June data not reported.

Table 9. General assistance: Recipients of money payments and amount of payments, by State, June 1969[1]

/Excludes vendor payments for institutional services in intermediate care facilities and for medical care and cases receiving only such payments/

State	Number of--		Payments to recipients			Percentage change from--			
				Average per--		May 1969 in--		June 1968 in--	
	Cases	Recipients	Total amount	Case	Recipient	Number of recipients	Amount	Number of recipients	Amount
Total 2/	384,000	769,000	$36,655,000	$95.40	$47.65	-3.6	-3.3	+5.0	+11.3
Ala.	82	83	1,100	13.40	13.25	(3/)	(3/)	(3/)	(3/)
Alaska	86	240	5,900	68.65	24.20	-41.6	-35.3	-43.9	-35.9
Ariz.	2,000	5,100	111,000	54.25	21.95	+20.6	+10.0	-10.2	+5.9
Ark.	210	690	3,000	14.35	4.40	-12.7	-6.6	+3.6	+14.6
Calif.	41,600	65,000	3,030,000	72.90	46.65	-29.0	-14.0	+35.6	+38.4
Colo.	900	2,600	39,900	44.30	15.15	-2.0	-9.6	-16.9	+1.1
Conn. 4/	6,800	20,300	679,000	100.00	33.55	-2.2	-2.0	+27.3	+37.2
Del.	2,300	5,100	138,000	60.95	27.20	-6.6	-5.1	+24.8	+20.5
D. C.	1,400	1,600	130,000	90.50	81.75	+1.7	-.8	+57.1	+75.9
Fla. 4/	7,800	19,400	253,000	---	---	---	---	---	---
Ga.	1,800	3,900	68,500	38.15	17.45	-7.1	-9.6	-28.6	-19.0
Guam	73	100	4,600	63.00	46.00	(3/)	(3/)	(3/)	(3/)
Hawaii	1,800	3,800	205,000	114.55	53.50	+2.5	+1.2	+57.5	+47.1
Ill.	28,500	58,100	2,922,000	102.65	50.25	+.7	+2.2	+11.7	+27.3
Iowa 4/	3,200	8,300	151,000	---	---	---	---	---	---
Kans.	3,200	6,100	294,000	93.15	48.40	-4.0	-1.9	+5.7	+22.8
La.	7,000	7,600	361,000	51.40	47.40	+1.0	+.3	+8.1	+8.9
Maine	2,000	5,900	74,300	37.40	12.50	-17.3	-22.0	-16.7	-16.3
Md.	5,700	6,600	499,000	87.50	75.70	+1.1	+.2	-14.7	-9.4
Mass.	13,400	24,800	1,462,000	109.10	58.90	-3.7	-3.7	+19.5	+58.5
Mich.	22,600	68,200	2,377,000	105.00	34.85	+3.7	-5.3	-1.4	+10.3
Minn.	6,200	17,400	609,000	98.10	35.00	-6.7	-7.1	-.3	+13.4
Miss.	1,300	1,500	22,800	17.90	14.95	-4.6	+4.9	-.8	-9.3
Mo.	10,600	12,800	682,000	64.30	53.20	+.1	-1.2	+2.4	+4.0
Mont.	750	2,200	38,100	51.10	17.45	-13.2	-20.0	-28.2	-28.5
N. H.	650	2,000	49,700	76.15	24.45	-14.7	-4.9	-3.3	+16.7
N. J. 5/	7,500	8,800	936,000	124.60	106.80	+.1	+4.6	-75.0	-38.0
N. Mex.	110	190	5,100	47.95	26.50	+42.2	+22.9	-69.4	-40.4
N. Y.	97,900	204,000	12,241,000	125.00	60.05	-1.8	-5.0	+3.2	-7.6
N. C.	1,400	3,300	40,100	28.85	12.30	-17.7	-22.1	-16.7	-14.7
N. Dak.	180	670	9,100	51.45	13.60	-24.0	-33.0	-24.3	-24.1
Ohio	19,500	50,400	1,912,000	98.10	37.90	+2.1	-6.8	-16.7	-10.6
Okla.	970	2,200	17,600	18.10	8.05	+5.5	+7.0	---	-4.4
Oreg.	2,400	5,000	158,000	67.20	31.55	+14.4	+16.7	---	+42.1
Pa.	46,800	70,800	5,160,000	110.35	72.95	+3.6	+7.8	+62.5	+103.0
R. I. 6/	3,400	10,000	254,000	74.60	25.45	---	---	---	---
S. C.	1,100	1,300	43,700	38.80	33.10	+.8	+.3	+47.3	+48.2
S. Dak.	200	680	7,500	36.55	11.05	-31.6	-27.1	-8.4	-11.7
Tenn.	1,700	4,600	47,900	27.90	10.40	+30.5	+13.2	+40.6	+8.3
Tex. 4/	7,700	(7/)	276,000	---	---	---	---	---	---
Utah 6/	1,300	1,300	95,500	73.85	73.25	---	---	---	---
Vt. 4/	400	(7/)	12,000	---	---	---	---	---	---
V. I.	170	190	7,500	43.60	39.05	+2.7	+4.2	+12.3	+14.5
Va.	5,400	11,500	333,000	61.30	29.00	+2.2	+2.5	+46.4	+56.4
Wash.	6,500	10,700	566,000	86.85	52.95	-8.8	-7.9	-15.3	-15.2
W. Va.	2,500	3,700	124,000	48.60	33.00	+2.4	+6.2	+46.2	+58.7
Wis. 6/	6,000	14,800	520,000	86.40	35.15	---	---	---	---
Wyo.	150	400	9,000	61.55	22.90	+2.9	-2.9	-24.8	-29.1

1/ All data subject to revision. Data include nonmedical vendor payments other than those for institutional services in intermediate care facilities.
2/ Partly estimated; does not represent sum of State figures because totals exclude for New Jersey an estimated number of cases and persons receiving only medical care, hospitalization, and/or burial and payments for such services; recipient count includes an estimate for States not reporting such data. Excludes Idaho, Indiana, Kentucky, Nevada, Nebraska, and Puerto Rico; data not available.
3/ Percentage change not computed on base of fewer than 100 recipients.
4/ Estimated.
5/ Includes an unknown number of cases and persons receiving only medical care, hospitalization, and/or burial and payments for such services.
6/ Data for May; June data not reported.
7/ Data not available.

Table 10. Institutional services in intermediate care facilities under old-age assistance, aid to the blind, and aid to the permanently and totally disabled: Recipients of such services and amount of payments, by State, June 1969[1]

State	Total, all programs 2/			Old-age assistance		
	Number of recipients	Payments for recipients		Number of recipients	Payments for recipients	
		Total amount	Average		Total amount	Average
Total	76,400	$17,948,000	$234.85	63,100	$15,003,000	$237.65
Colo	3,200	767,000	236.95	2,400	579,000	238.75
Ga	490	80,700	165.00	420	69,500	164.20
Ill	16,200	3,496,000	216.20	13,100	2,736,000	209.20
Kans	3,200	601,000	189.35	2,400	436,000	185.25
La	250	29,700	118.75	200	24,000	117.10
Maine	2,400	565,000	231.25	2,200	509,000	229.40
Md	920	204,000	220.60	760	161,000	211.65
Mass	6,600	1,508,000	228.85	5,500	1,289,000	235.85
Mich	4,200	1,422,000	341.35	3,500	1,171,000	337.80
Nebr	5,500	980,000	177.70	3,700	664,000	177.70
N. Mex	800	561,000	705.45	640	439,000	687.55
Oreg	5,300	824,000	155.90	4,200	662,000	155.95
R. I	1,600	222,000	142.05	1,100	156,000	139.95
S. C	120	23,100	185.05	97	17,700	182.10
S. Dak	1,700	329,000	197.15	1,500	291,000	195.75
Tex	19,700	5,652,000	286.20	18,700	5,350,000	286.80
Utah 3/	1,600	243,000	147.00	890	126,000	141.30
Vt	730	190,000	259.50	660	172,000	259.45
Wash	1,900	251,000	132.80	1,200	149,000	124.55

1/ All data subject to revision. Data represent payments to vendors of institutional services in intermediate care facilities. Federal financial participation in such payments is limited to those in behalf of individuals who qualify for OAA, AB, or APTD under programs operated under State plans approved under titles I, X, XIV, or XVI.

2/ Includes a few payments of this type made without Federal participation for recipients of AFDC or GA.

3/ Represents data for May; June data not reported.

2/ Includes a few payments of this type made without Federal participation for recipients of AFDC or GA.
3/ Represents data for May; June data not reported.

Table 11. Amount of vendor payments for medical care for recipients of public assistance, by program and State, June 1969[1]

State	Total	Percentage change from--		Medical assistance	Medical assistance for the aged	Old-age assistance	Aid to the blind	Aid to the permanently and totally disabled	Aid to families with dependent children	General assistance 2/
		May 1969	June 1968							
Total	$379,029,000	-2.1	+8.4	$351,267,000	$5,007,000	$9,938,000	$248,000	$3,774,000	$2,810,000	$5,986,000
Ala.	1,842,000	-.6	+18.8	---	88	1,674,000	9,100	159,000	---	---
Alaska 3/	254,000	+19.2	+31.6	---	---	62,100	1,100	35,000	---	156,000
Ariz.	201,000	-2.9	+31.4	---	---	201,000	---	---	---	---
Ark. 3/	2,016,000	-.3	+12.6	---	473,000	1,039,000	27,900	389,000	86,700	---
Calif.	74,616,000	+7.6	+18.6	74,616,000	---	---	---	---	---	---
Colo.	3,259,000	-21.3	+42.8	3,229,000	---	---	---	---	---	30,000
Conn.	3,964,000	-28.9	-37.5	3,813,000	---	---	---	---	---	151,000
Del.	323,000	+14.1	+35.1	323,000	---	---	---	---	---	---
D. C.	853,000	-30.1	+622.9	852,000	---	---	---	---	---	880
Fla. 3/	2,476,000	+10.9	+12.4	---	---	1,890,000	22,100	333,000	231,000	---
Ga.	8,644,000	+57.8	+59.9	8,644,000	---	---	---	---	---	---
Guam	14,500	-3.3	+663.2	14,400	---	---	---	---	---	130
Hawaii	1,444,000	+30.2	+113.0	1,292,000	---	---	---	---	---	152,000
Idaho	748,000	+10.3	+36.0	748,000	---	---	---	---	---	---
Ill.	13,271,000	+1.8	-6.2	11,605,000	---	---	---	---	---	1,666,000
Ind.	3,541,000	+.1	+26.6	---	585,000	1,503,000	107,000	737,000	609,000	---
Iowa	1,898,000	-5.3	-12.5	1,898,000	---	---	---	---	---	---
Kans.	737,000	-75.8	-80.8	737,000	---	---	---	---	---	---
Ky.	2,828,000	-61.3	-32.3	2,828,000	---	---	---	---	---	---
La.	5,842,000	+27.0	+32.7	5,740,000	---	---	---	---	---	102,000
Maine	1,006,000	+14.7	-19.3	933,000	---	---	---	---	---	72,900
Md.	12,355,000	+131.6	+34.5	12,355,000	---	---	---	---	---	---
Mass.	20,427,000	+3.3	-6.9	19,853,000	---	---	---	---	---	574,000
Mich.	16,956,000	+11.0	-3.2	16,777,000	---	---	---	---	---	179,000
Minn.	8,828,000	-1.3	+13.4	8,359,000	---	---	---	---	---	469,000
Miss.	493,000	+1.0	+48.9	---	---	417,000	5,000	70,700	---	---
Mo.	8,182,000	+52.6	+88.7	8,182,000	---	---	---	---	---	---
Mont.	1,094,000	+5.6	+28.4	808,000	---	---	---	---	---	286,000
Nebr.	859,000	-22.3	-51.4	859,000	---	---	---	---	---	---
Nev.	680,000	+20.6	+13.1	680,000	---	---	---	---	---	---
N. H.	523,000	-7.3	-33.1	523,000	---	---	---	---	---	---
N. J.	5,442,000	+5.0	+22.2	---	4/ 3,444,000	279,000	17,900	483,000	889,000	329,000
N. Mex.	1,652,000	+98.1	+4.6	1,648,000	---	---	---	---	---	3,900
N. Y.	91,866,000	-11.3	+4.1	91,866,000	---	---	---	---	---	---
N. C. 3/	2,349,000	+9.2	+30.1	---	193,000	332,000	18,600	1,046,000	616,000	139,000
N. Dak.	943,000	-13.6	+11.9	936,000	---	---	---	---	---	7,000
Ohio	10,597,000	-9.9	+33.5	9,688,000	---	---	---	---	---	910,000
Okla.	6,526,000	-1.2	-.3	6,526,000	---	---	---	---	---	---
Oreg.	1,426,000	+20.3	-9.6	1,311,000	---	---	---	---	---	115,000
Pa.	5,290,000	-72.3	-62.4	5,290,000	---	---	---	---	---	---
P. R.	4,255,000	+25.0	+33.5	4,255,000	---	---	---	---	---	---
R. I.	3,654,000	+15.8	+42.5	3,461,000	---	---	---	---	---	193,000
S. C.	3,673,000	+124.1	+340.9	3,673,000	---	---	---	---	---	---
S. Dak.	723,000	+10.7	-3.3	648,000	---	---	---	---	---	75,400
Tenn.	2,016,000	+12.2	+40.0	---	170,000	1,564,000	6,200	126,000	150,000	---
Tex.	17,199,000	+16.9	+45.8	17,199,000	---	---	---	---	---	---
Utah 5/	434,000	---	---	434,000	---	---	---	---	---	260
Vt.	600,000	-37.0	-39.7	600,000	---	---	---	---	---	---
V. I. 5/	65,500	---	---	65,500	---	---	---	---	---	---
Va.	1,873,000	+64.3	+94.5	---	142,000	977,000	32,600	395,000	228,000	98,300
Wash.	4,979,000	-26.7	+14.9	4,979,000	---	---	---	---	---	---
W. Va.	1,085,000	-9.1	-4.7	1,006,000	---	---	---	---	---	79,100
Wis. 6/	12,059,000	-2.3	+7.5	11,923,000	---	---	---	---	---	136,000
Wyo.	151,000	-12.7	-12.7	90,200	---	---	---	---	---	61,100

1/ Amounts represent primarily bills paid during the month and therefore are subject to fluctuations unrelated to provisions of medical services. All data subject to revision.
2/ Data incomplete for general assistance. Some States do not report these data and for some the data represent only partial reporting.
3/ Except for aid to families with dependent children and general assistance, data represent payments for recipients of the specified types of assistance under program for aid to the aged, blind, or disabled or for such aid and medical assistance for the aged.
4/ Excludes small amount of money payments not subject to Federal participation.
5/ Data for June not reported; data represent amounts reported for a previous month.
6/ Distribution estimated.

Table 12. Amount of medical vendor payments for public assistance programs under the Social Security Act, by form of payment and State, June 1969[1]

State	Total	Form of medical vendor payments	
		Payments to vendors directly or through fiscal agent	Premium or per capita payments 2/
Total	$373,044,000	$354,756,000	$18,288,000
Title XIX States	351,267,000	336,981,000	14,286,000
Other States	21,777,000	17,775,000	4,002,000
	Title XIX States		
Calif	74,616,000	73,483,000	1,133,000
Colo	3,229,000	3,229,000	---
Conn	3,813,000	3,813,000	---
Del	323,000	315,000	8,400
D. C	852,000	852,000	---
Ga	8,644,000	8,239,000	405,000
Guam	14,400	13,300	1,200
Hawaii	1,292,000	1,292,000	---
Idaho	748,000	726,000	22,300
Ill	11,605,000	11,440,000	165,000
Iowa	1,898,000	1,802,000	95,500
Kans	737,000	643,000	94,000
Ky	2,828,000	2,573,000	255,000
La	5,740,000	5,740,000	---
Maine	933,000	884,000	48,800
Md	12,355,000	12,355,000	---
Mass	19,853,000	19,852,000	1,500
Mich	16,777,000	16,621,000	156,000
Minn	8,359,000	8,265,000	93,500
Mo	8,182,000	7,811,000	371,000
Mont	808,000	793,000	14,800
Nebr	859,000	808,000	50,900
Nev	680,000	680,000	---
N. H	523,000	504,000	18,600
N. Mex	1,648,000	1,648,000	---
N. Y	91,866,000	91,632,000	234,000
N. Dak	936,000	884,000	2/ 51,400
Ohio	9,688,000	9,421,000	267,000
Okla	6,526,000	1,596,000	2/ 4,930,000
Oreg	1,311,000	1,280,000	2/ 31,100
Pa	5,290,000	5,290,000	---
P. R	4,255,000	4,255,000	---
R. I	3,461,000	3,446,000	14,900
S. C	3,673,000	3,579,000	94,700
S. Dak	648,000	630,000	18,500
Tex	17,199,000	11,701,000	2/ 5,498,000
Utah 3/	434,000	417,000	17,200
Vt	600,000	580,000	19,100
V. I. 3/	65,600	65,500	---
Wash	4,979,000	4,834,000	2/ 145,000
W. Va	1,006,000	1,006,000	---
Wis. 4/	11,923,000	11,893,000	30,000
Wyo	90,200	90,200	---
	Other States		
Ala	1,843,000	1,843,000	---
Alaska	98,200	98,200	---
Ariz	201,000	158,000	43,400
Ark	2,016,000	1,771,000	245,000
Fla	2,476,000	2,206,000	270,000
Ind	3,540,000	3,280,000	2/ 260,000
Miss	493,000	493,000	---
N. J	5,112,000	5,051,000	61,400
N. C	2,206,000	1,031,000	2/ 1,175,000
Tenn	2,015,000	172,000	2/ 1,843,000
Va	1,775,000	1,671,000	2/ 104,000

1/ All data subject to revision.
2/ Entries represent premium payments into the Social Security Administration system for Supplementary Medical Insurance except for premium payments into an agency pooled fund by North Carolina-$1,175,000; Oklahoma-$4,630,000; Tennessee-$1,602,000; and premium payments to health-insuring agencies by Indiana-$185,000; North Dakota-$33,000; Oregon-$31,100; Texas-$3,957,000; Virginia-$59,800; and Washington-$5,900.
3/ Data for June not reported; data represent amount reported for a previous month.
4/ Distribution by form of payment estimated.

Table 13. General assistance: Recipients of money payments and amount of payments for selected cities, June 1969

[Excludes vendor payments for institutional services in intermediate care facilities and for medical care and cases receiving only such payments]

City	Number of--		Payments to recipients			Percentage change from			
	Cases	Recipients	Total amount	Average per--		May 1969 in--		June 1968 in--	
				Case	Recipient	Number of recipients	Amount	Number of recipients	Amount
Total, 17 cities 1/.....	191,000	352,000	$20,226,000	$105.95	$57.45	-7.8	-5.7	+1.9	+8.3
Baltimore.....	4,700	5,400	417,000	88.05	76.70	+1.7	+.4	-17.7	-11.9
Boston.....	6,200	8,600	679,000	109.35	78.70	+3.2	-3.7	+34.5	+49.9
Buffalo 2/.....	4,200	6,500	513,000	121.80	78.60	-2.2	+1.4	+7.8	+24.3
Chicago.....	20,100	38,300	2,407,000	119.70	62.80	(3/)	(3/)	+19.3	+34.2
Cincinnati 2/ 4/.....	4,200	12,800	313,000	74.90	24.45	-7.1	-4.1	-22.6	-18.1
Cleveland 2/ 4/.....	8,700	23,100	805,000	92.20	34.85	-1.3	-13.8	+31.4	+38.5
Detroit.....	(1/)	(1/)	(1/)	---	---	---	---	---	---
District of Columbia.....	1,400	1,600	130,000	90.50	81.75	+1.7	-.8	+57.1	+75.9
Los Angeles 2/.....	21,900	39,100	1,334,000	60.90	34.15	-38.6	-26.7	+55.0	+30.4
Milwaukee 5/.....	4,300	9,500	388,000	90.60	40.90	---	---	---	---
Minneapolis.....	1,400	3,000	123,000	85.10	41.35	-7.0	-6.5	-15.8	-13.9
New Orleans.....	1,300	1,400	71,200	54.95	51.20	+3.4	+2.3	+23.8	+27.0
New York.....	75,400	151,000	9,140,000	121.25	60.65	-1.3	-6.4	+2.0	-16.2
Philadelphia.....	16,500	25,000	2,009,000	121.90	80.25	+3.7	+10.1	+59.4	+123.7
Pittsburgh.....	10,300	13,500	1,051,000	102.45	77.95	+4.5	+1.8	+43.0	+62.6
Rochester 5/.....	1,100	2,800	128,000	117.55	45.10	---	---	---	---
St. Louis.....	2,200	2,400	137,000	63.55	58.10	+.7	-.2	+8.5	+8.1
San Francisco.....	7,100	8,300	583,000	82.65	69.95	-3.4	-1.5	+5.4	+48.1

1/ Data not reported for Detroit. Percentage changes based on comparable data.
2/ Data for county in which city is located.
3/ Data not reported in May 1969.
4/ Includes supplementation of categorical cases; not included in State data.
5/ Represents data for May; June data not reported.

Table 14. Aid to families with dependent children: Assessments completed and referrals to manpower agencies by welfare agencies, and enrollments by manpower agencies under Work Incentive Program, by State, cumulative through June 1969[1]

State	Assessments completed			Referrals		Cumulative enrollments		Training spaces approved for fiscal year 1969	Individuals enrolled at end of period	
	Total	Appropriate for referral		Number	Percent of appropriate for referral	Number	Percent of referrals		Number	Percent of training spaces
		Number	Percent of assessments completed							
Total	963,980	194,531	20.2	143,371	73.7	80,607	56.2	84,753	66,131	78.0
Ala.	6,016	1,410	23.4	1,281	90.9	815	63.6	800	663	82.9
Alaska	633	327	51.7	327	100.0	335	2/ 102.4	200	253	3/ 126.5
Ariz.	9,806	3,376	34.4	1,272	37.7	1,271	99.9	1,200	981	81.8
Calif.	185,497	65,902	35.5	58,848	89.3	26,786	45.5	12,000	21,197	3/ 176.6
Colo.	7,906	3,011	38.1	1,249	41.5	1,126	90.2	1,000	858	85.8
Conn.	11,229	2,227	19.8	2,227	100.0	1,385	62.2	1,200	1,071	89.3
D. C. 4/	1,416	1,074	75.8	1,074	100.0	1,276	5/ 118.8	1,200	1,018	84.8
Guam	(6/)	(6/)	---	(6/)	---	59	---	50	49	98.0
Hawaii	30,805	2,060	6.7	1,153	56.0	267	23.2	300	212	70.7
Ill.	8,689	5,559	64.0	5,043	90.7	1,849	36.7	5,000	1,544	30.9
Iowa	510	344	67.5	99	28.8	393	2/ 397.0	700	380	54.3
Kans.	2,705	1,070	39.6	862	80.6	712	82.6	700	521	74.4
Ky.	13,688	6,881	50.3	1,838	26.7	1,509	82.1	2,000	1,381	69.1
La.	6,296	1,142	18.1	616	53.9	551	89.4	700	479	68.4
Maine	1,039	453	43.6	301	66.4	146	48.5	400	100	25.0
Md.	21,348	3,194	15.0	2,978	93.2	1,807	60.7	2,400	1,607	67.0
Mass. 7/	7,930	3,853	48.6	5,009	7/ 130.0	2,543	50.8	3,000	2,209	73.6
Mich.	46,405	6,714	14.5	6,714	100.0	4,049	60.3	5,000	3,520	70.4
Miss.	4,196	2,145	51.1	203	9.5	192	94.6	1,000	154	15.4
Mo.	3,338	1,309	39.2	1,309	100.0	1,137	86.9	1,800	846	47.0
Mont.	1,092	468	42.9	392	83.8	340	86.7	300	244	81.3
N. J.	7,077	6,005	84.9	5,906	98.4	3,236	54.8	2,600	2,860	3/ 110.0
N. Y.	483,611	33,708	7.0	9,063	26.9	5,517	60.9	12,000	5,124	42.7
N. Dak.	522	367	70.3	356	97.0	264	74.2	200	215	3/ 107.5
Ohio	11,339	7,000	61.7	4,300	61.4	2,675	62.2	4,600	2,154	46.8
Pa.	21,055	6,309	30.0	5,990	94.9	3,895	65.0	5,600	3,420	61.1
P. R.	16,417	5,065	30.9	4,067	80.3	2,220	54.6	3,500	1,886	53.9
R. I.	2,898	1,022	35.3	1,021	99.9	582	57.0	600	475	79.2
S. Dak.	1,198	713	59.5	209	29.3	221	8/ 105.7	400	201	50.3
Tenn.	8,330	1,754	21.1	1,251	71.3	1,078	86.2	1,200	900	75.0
Utah	1,193	1,100	92.2	1,100	100.0	1,105	8/ 100.5	900	815	90.6
Vt.	705	450	63.8	323	71.8	236	73.1	200	162	81.0
V. I.	(6/)	(6/)	---	(6/)	---	(6/)	---	43	(6/)	---
Va.	1,236	675	54.6	633	93.8	530	83.7	800	500	62.5
Wash.	25,896	9,162	35.4	8,546	93.3	3,282	38.4	1,800	2,254	3/ 125.2
W. Va.	6,809	6,562	96.4	6,227	94.9	5,816	93.4	7,400	4,614	62.4
Wis.	4,475	1,948	43.5	1,428	73.3	1,285	90.0	1,860	1,175	63.2
Wyo.	675	172	25.5	156	90.7	117	75.0	100	89	89.0

1/ Data cover all jurisdictions participating in program for all or part of fiscal year 1969. Sources of data: assessments and referrals - Department of Health, Education, and Welfare; enrollments and training spaces - Department of Labor.
2/ Excess of enrollments over referrals under investigation.
3/ Enrollments exceed approved training spaces because of trainees in holding status, i.e., awaiting assignment or reassignment to training activity.
4/ Data on assessments and referrals exclude non-AFDC recipients under Temporary Assistance Program for Families of Unemployed Parents.
5/ Enrollments exceed referrals because enrollees include persons in the Temporary Assistance Program for Families of Unemployed Parents who are not referred through the regular referral processes.
6/ Not reported.
7/ Data for referrals beginning October 1968; data for assessments beginning December 1968.
8/ Enrollments exceed referrals because some trainees under title V of the Economic Opportunity Act were assigned directly to WIN projects without reassessment.

Table 15. Proportion of population receiving public assistance money payments (recipient rates), by State, June 1969[1]

[Excludes recipients receiving only vendor payments for medical care. All data subject to revision]

State	All recipients per 1,000 population		Recipients of old-age assistance per 1,000 population age 65 and over	Recipients of aid to the blind per 100,000 population age 18 and over	Recipients of aid to the permanently and totally disabled per 1,000 population aged 18-64	Children receiving aid to families with dependent children		Recipients of general assistance per 1,000 population under age 65
	Including General assistance	Excluding General assistance				Per 1,000 population under age 18	Per 1,000 population under age 21	
U. S. average....	50	47	104	61	6.8	68	60	2/ 4.7
Ala.....	68	68	373	88	8.9	66	57	(3/)
Alaska.....	38	37	188	76	5.3	44	40	1.0
Ariz.....	41	38	87	56	7.1	52	47	3.3
Ark.....	58	58	270	141	10.6	44	38	.4
Calif.....	81	77	182	4/ 105	14.0	107	94	3.7
Colo.....	52	50	209	15	6.9	58	51	1.4
Conn.....	38	31	27	12	3.6	57	50	7.5
Del.....	50	41	43	109	4.5	67	60	10.3
D. C.....	54	52	37	38	11.0	92	83	2.2
Fla.....	46	43	85	57	6.2	66	58	3.6
Ga.....	64	63	260	114	12.6	72	63	.9
Guam.....	22	21	146	16	1.2	27	25	1.1
Hawaii.....	39	34	46	15	4.2	52	46	5.5
Idaho.....	5/ 27	27	49	24	7.4	35	31	(5/)
Ill.....	43	38	34	24	6.1	68	60	5.9
Ind.....	5/ 16	16	35	45	1.6	25	22	(5/)
Iowa.....	34	31	67	57	1.8	44	39	3.4
Kans.....	32	29	54	25	4.6	46	40	3.0
Ky.....	5/ 64	64	195	105	8.7	79	68	(5/)
La.....	89	87	407	108	11.3	94	83	2.2
Maine.....	51	44	89	35	6.3	63	56	7.0
Md.....	40	38	31	14	7.2	66	59	1.9
Mass.....	50	46	80	71	5.2	73	64	5.2
Mich.....	40	32	49	25	4.8	50	44	8.5
Minn.....	31	27	55	34	4.7	38	33	5.3
Miss.....	87	87	334	155	17.9	96	83	.7
Mo.....	54	51	163	4/ 126	7.2	61	54	3.2
Mont.....	28	25	53	38	5.1	34	30	3.5
Nebr.....	5/ 27	27	44	37	4.9	40	35	(5/)
Nev.....	5/ 28	28	111	65	---	41	38	(5/)
N. H.....	21	18	52	50	2.0	23	21	3.2
N. J.....	36	35	22	19	2.8	69	61	6/ 1.4
N. Mex.....	63	63	135	66	14.6	81	72	.2
N. Y.....	74	63	43	28	6.0	121	107	12.5
N. C.....	37	36	93	144	8.9	47	41	.7
N. Dak.....	28	27	59	22	6.4	34	30	1.2
Ohio.....	36	32	58	40	4.9	49	43	5.2
Okla.....	74	73	262	81	14.1	79	69	1.0
Oreg.....	34	32	34	35	4.2	55	47	2.8
Pa.....	45	39	36	112	4.0	71	62	6.7
P. R.....	5/ 85	85	136	51	10.1	117	102	(5/)
R. I.....	60	48	37	20	7.4	86	76	12.7
S. C.....	28	28	104	117	6.8	33	29	.5
S. Dak.....	33	32	57	28	4.3	46	40	1.2
Tenn.....	48	47	135	69	9.5	64	56	1.3
Tex.....	5/ 38	38	242	60	3.4	31	27	(5/)
Utah 7/.....	39	38	62	24	9.6	48	42	1.3
Vt.....	5/ 40	40	79	37	7.5	55	48	(5/)
V. I.....	43	40	123	23	2.6	60	51	3.4
Va.....	23	20	32	37	2.9	33	29	2.8
Wash.....	38	35	74	21	7.0	49	43	3.5
W. Va.....	58	56	57	47	6.5	97	83	2.3
Wis.....	29	26	39	24	2.9	41	36	3.9
Wyo.....	24	23	66	21	4.8	30	26	1.4

1/ Based on civilian population as of July 1, 1969; estimated by the Bureau of the Census.
2/ Based on data for 46 States. See footnote 5.
3/ Less than 0.05.
4/ Includes recipients of payments made without Federal participation. Recipient rates excluding these recipients are as follows: California, 103 and Missouri, 109.
5/ Number of persons aided under general assistance program not currently available.
6/ Includes an unknown number of persons receiving medical care, hospitalization, and burial only.
7/ Represents data for May; June data not reported.

Data for referrals beginning October 1968; data for assessments beginning December 1968. Enrollments exceed referrals because some trainees under title V of the Economic Opportunity Act were assigned directly to WIN projects without reassessment.

Table 16. Old-age, survivors, disability, and health insurance, summary benefit data, June 1969[1]

CASH BENEFITS AWARDED AND IN CURRENT-PAYMENT STATUS

Type of beneficiary	Benefit awards		Benefits in current-payment status			Amount of benefits paid 1/ (in thousands)
	Number	Average amount	Number	Average amount	Monthly rate (in thousands)	
Total monthly beneficiaries	300,706	---	24,877,896	---	$2,106,132	$2,223,620
Retired workers and dependents	141,299	---	15,737,800	---	1,410,247	1,466,585
Retired workers	99,752	$105.33	12,581,528	$99.69	1,254,238	1,296,023
Wives and husbands	26,622	49.79	2,633,531	51.57	135,806	149,078
Children 2/	14,925	42.28	522,741	38.65	20,203	21,484
Disabled workers and dependents	69,529	---	2,406,980	---	188,364	215,592
Disabled workers	32,170	118.81	1,342,556	112.20	150,634	171,011
Wives and husbands	8,569	39.95	254,331	37.94	9,650	11,558
Children 2/	28,790	35.46	810,093	34.66	28,079	33,023
Survivors of deceased workers	86,072	---	6,098,198	---	482,632	515,873
Widowed mothers	8,409	75.92	497,150	74.59	37,082	39,942
Children 2/	47,409	69.49	2,559,421	70.85	181,328	192,716
Widows and widowers 3/	30,104	90.48	3,010,878	86.85	261,500	280,224
Parents	150	101.44	30,749	88.53	2,722	2,991
Special age-72 beneficiaries 4/	3,806	---	634,918	---	24,889	25,571
Primary	3,701	---	617,351	39.75	24,538	25,210
Wives	105	---	17,567	19.96	351	361
Lump-sum death payments 5/	99,439	233.01	---	---	---	22,290

1/ Exceeds monthly rate of benefits in current-payment status because of the inclusion in initial payments of amounts payable for prior months. Distribution by type of monthly benefit estimated.

2/ Includes disabled persons aged 18 and over whose disability began before age 18.

3/ Includes actuarially reduced benefits for widows and divorced wives aged 60-61; a total of 130,406 such beneficiaries were in current-payment status. Also includes disabled widows and widowers aged 50-61; a total of 31,796 such persons were in current-payment status.

4/ Represents benefits authorized by Public Law 89-368(1966) for certain persons aged 72 and over who are not insured under the regular or transitional insured status provisions of the Social Security Act.

5/ Number of lump-sum death payments shown were paid on the accounts of 95,662 deceased workers; the average amount represents average per deceased worker.

July Tables

Table 1. Recent changes in public assistance: Recipients, payments, and money payments per recipient, July 1969, compared with selected earlier months

Program	Two years ago July 1967	One year ago July 1968	Last month June 1969	This month July 1969
RECIPIENTS OF MONEY PAYMENTS:				
Old-Age Assistance	2,062,000	2,019,000	2,036,000	2,041,000
Aid to the Blind	83,000	81,000	80,200	80,100
Aid to the Permanently and Totally Disabled	618,000	674,000	755,000	763,000
Aid to Families with Dependent Children: Families	1,212,000	1,397,000	1,661,000	1,681,000
Persons	4,978,000	5,636,000	6,558,000	6,613,000
Children	3,745,000	4,229,000	4,880,000	4,917,000
General Assistance:				
Cases	313,000	367,000	384,000	390,000
Persons	678,000	768,000	769,000	784,000
ASSISTANCE PAYMENTS (In 000's):				
Total	$629,482	$802,207	$938,338	$963,606
Money payments:				
Total	408,221	473,443	539,993	549,007
Old-Age Assistance	141,668	138,160	143,625	144,738
Aid to the Blind	7,295	7,411	7,643	7,631
Aid to the Permanently and Totally Disabled	47,951	55,125	64,650	65,801
Aid to Families with Dependent children	185,476	237,510	287,420	293,003
General Assistance	25,831	35,237	36,655	37,834
Medical Assistance:				
Total	221,261	328,445	380,397	394,007
Medical Assistance	190,184	303,900	352,530	367,337
Medical Assistance for the Aged	6,472	5,961	5,007	5,088
Other Federally Aided	20,277	13,763	16,770	15,204
General Assistance	4,328	4,821	6,090	6,378
Emergency assistance	---	---	---	757
Payments to intermediate care facilities	---	319	17,948	19,835
MONEY PAYMENTS PER RECIPIENT:				
Old-Age Assistance	$68.70	$68.45	$70.55	$70.95
Aid to the Blind	88.05	91.50	95.35	95.30
Aid to the Permanently and Totally Disabled	77.55	81.85	85.65	86.25
Aid to Families with Dependent Children:				
Average per family	153.05	170.00	173.00	174.25
Average per person	37.25	42.15	43.85	44.30
General Assistance:				
Average per case	82.60	96.05	95.40	96.90
Average per person	38.00	45.90	47.65	48.25

Table 2. Amount of public assistance payments in the United States, by month, July 1968-July 1969[1]

Year and month	Total	Money payments to recipients 2/							Medical assistance 3/						Emergency assistance 4/	Payments to intermediate care facilities 5/
		Total	Federally aided programs					General assistance 6/	Total	Federally aided programs				General assistance 6/		
			Total	Old-age assistance	Aid to the blind	Aid to the permanently and totally disabled	Aid to families with dependent children			Total	Medical assistance (Title XIX)	Medical assistance for the aged (Title I and XVI)	Other 7/			
	Amount of assistance (In thousands)															
1968																
July	$802,207	$473,443	$438,206	$138,160	$7,411	$55,125	$237,510	$35,237	$328,445	$323,624	$303,900	$5,961	$13,763	$4,821	---	$319
August 8/	841,629	499,573	459,891	139,306	7,437	56,146	257,002	39,682	340,820	335,782	315,866	5,381	14,535	5,038	---	1,236
September	821,735	478,267	440,985	138,087	7,364	55,588	239,946	37,282	341,647	336,215	316,508	5,525	14,182	5,432	---	1,821
October	859,071	486,903	450,659	139,327	7,396	56,696	247,240	36,244	370,183	365,226	345,064	5,678	14,484	4,957	---	1,985
November	862,531	484,932	449,378	138,678	7,368	56,728	246,604	35,554	375,566	370,196	349,902	5,722	14,572	5,370	---	2,033
December 8/	879,995	521,443	480,811	142,189	7,486	58,676	272,460	40,632	356,469	351,377	330,893	5,753	14,731	5,092	---	2,083
1969																
January	899,967	513,872	475,233	141,287	7,487	59,322	267,137	38,639	379,288	373,061	354,898	4,315	13,848	6,227	---	6,807
February	915,892	519,552	482,215	141,990	7,478	60,533	272,214	37,337	383,862	378,095	359,860	4,315	13,920	5,767	---	12,478
March 8/	938,607	551,297	509,656	144,628	7,625	62,339	295,064	41,641	374,027	368,412	349,087	4,525	14,800	5,615	---	13,283
April	944,665	535,082	496,886	143,307	7,577	62,751	283,251	38,196	394,667	388,939	369,261	4,691	14,987	5,728	---	14,916
May	937,610	534,971	497,084	143,623	7,580	63,990	281,891	37,887	387,194	380,922	360,686	4,821	15,415	6,272	---	15,445
June	938,338	539,993	503,338	143,625	7,643	64,650	287,420	36,655	380,397	374,307	352,530	5,007	16,770	6,090	---	17,948
July	963,606	549,007	511,173	144,738	7,631	65,801	293,003	37,834	394,007	387,629	367,337	5,088	15,204	6,378	$757	19,835
	Percentage change from preceding month															
1968																
July	-1.7	+1.6	+1.1	+0.8	+0.3	+1.5	+1.2	+6.9	-6.1	-6.2	-6.4	+8.8	-7.0	+1.1	---	---
August 8/	+2.5	+1.4	+1.0	(9/)	-.3	+.7	+1.7	+3.1	+3.8	+3.8	+3.9	-9.7	+5.6	+4.5	---	+287.7
September	+.1	-.2	-.4	-.1	-.3	+.1	-.7	+2.8	+.2	+.1	+.2	+2.7	-2.4	+7.8	---	+47.3
October	+4.5	+1.8	+2.2	+.9	+.4	+2.0	+3.0	-2.8	+8.4	+8.6	+9.0	+2.8	+2.1	-8.7	---	+9.0
November	+.4	-.4	-.3	-.5	-.4	+.1	-.3	-1.9	+1.5	+1.4	+1.4	+.8	+.6	+6.2	---	+2.4
December 8/	-.5	+3.0	+2.9	+1.7	+1.0	+2.3	+3.5	+4.1	-4.3	-4.3	-4.6	+.5	+1.1	-7.2	---	+2.5
1969																
January	+2.4	+3.6	+2.8	+.1	+.7	+2.2	+4.2	+3.9	+6.4	+6.2	+7.3	-25.0	-6.0	+22.2	---	+226.8
February	+1.7	+1.1	+1.5	+.5	-.1	+2.0	+1.9	-3.4	+1.2	+1.1	+1.1	0	+.5	-7.4	---	+83.3
March 8/	(10/)	+1.7	+1.9	+1.0	+1.3	+1.7	+2.1	+2.1	-2.6	-2.6	-3.0	+6.3	+6.3	-2.6	---	+6.5
April	+3.2	+1.2	+1.3	-.1	-.6	+1.9	+2.0	+.1	+5.5	+5.6	+5.8	+3.7	+1.3	+2.0	---	+12.3
May	-.7	(10/)	(9/)	+.2	(9/)	+2.0	-.5	-.8	-1.9	-2.1	-2.3	+2.8	+5.5	+9.5	---	+3.5
June	+.1	+.9	+1.3	(9/)	+.8	+1.0	+2.0	-3.3	-1.8	-1.7	-2.3	+3.9	+8.8	-2.9	---	+16.2
July	+2.7	+1.7	+1.6	+.8	-.2	+1.8	+1.9	+3.2	+3.6	+3.6	+4.2	+1.6	-9.3	+4.7	---	+10.5
	Percentage change from same month of preceding year															
1969																
July	+20.1	+16.0	+16.7	+4.8	+3.0	+19.4	+23.4	+7.4	+20.0	+19.8	+20.9	-14.6	+10.5	+32.3	---	---

1/ All data subject to revision.
2/ Includes nonmedical vendor payments other than those for institutional services in intermediate care facilities.
3/ Amounts represent primarily bills paid to medical vendors during the month and therefore are subject to fluctuations unrelated to provisions of medical services.
4/ Data include both money payments to families and medical vendor payments. Such emergency assistance to needy families with children authorized under title IV. Data not available for months prior to July 1969.
5/ Data represent payments to vendors of institutional services in intermediate care facilities. Federal financial participation in such payments is limited to those in behalf of individuals who qualify for OAA, AB, or APTD under programs operated under State plans approved under titles I, X, XIV, or XVI.
6/ Partly estimated. Does not include Idaho, Indiana, Kentucky, Nebraska, Nevada and Puerto Rico; data not available.
7/ Data represent payments to medical vendors under maintenance assistance programs operated under approved State plans under titles I, IV, X, XIV, or XVI.
8/ Amounts for money payments include a special grant of $25.00 per person (aggregating $20,500,000 in August, $22,002,000 in December, and $22,807,000 in March) issued quarterly in New York City. Percentage changes based on data excluding these amounts.
9/ Increase of less than 0.05 percent.
10/ Decrease of less than 0.05 percent.

Note: Beginning with the March 1969 release, the total in column 2 is the sum of the money payment columns; previously it also included payments to intermediate care facilities.

Note: Beginning with the March 1969 release, the total in column 1 is the sum of the money payments columns; previously it also included payments to intermediate care facilities.

Table 3. Number of recipients of public assistance maintenance payments in the United States, by month, July 1968-July 1969[1]

Year and month	Recipients of money payments 2/										Families receiving emergency assistance 3/	Recipients of institutional services in intermediate care facilities 4/
	Total	Federally aided programs							General assistance 5/			
		Total	Old-age assistance	Aid to the blind	Aid to the permanently and totally disabled	Aid to families with dependent children						
						Families	Total recipients 6/	Children	Cases	Recipients		
	Number of recipients (In thousands)											
1968												
July	9,178	8,410	2,019	81.0	674	1,397	5,636	4,229	367	768	---	2.6
August	9,274	8,490	2,022	81.0	680	1,420	5,707	4,275	375	784	---	7.6
September	9,425	8,588	2,021	81.0	684	1,444	5,802	4,351	383	837	---	12.3
October	9,480	8,680	2,025	81.0	691	1,471	5,883	4,409	382	800	---	12.7
November	9,561	8,763	2,026	81.0	696	1,490	5,960	4,465	382	798	---	13.0
December	9,723	8,896	2,027	80.7	702	1,522	6,086	4,555	392	827	---	13.6
1969												
January	9,892	9,038	2,025	80.5	711	1,556	6,221	4,650	404	854	---	7/ 23.4
February	10,027	9,199	2,025	80.3	718	1,591	6,376	4,743	402	828	---	58.2
March	10,143	9,316	2,030	80.4	728	1,621	6,478	4,815	404	827	---	60.4
April	10,193	9,387	2,031	80.2	738	1,641	6,538	4,860	397	806	---	66.6
May	10,197	9,399	2,034	79.9	747	1,650	6,538	4,864	398	798	---	68.8
June	10,198	9,429	2,036	80.2	755	1,661	6,558	4,880	384	769	---	76.4
July	10,281	9,497	2,041	80.1	763	1,681	6,613	4,917	390	784	6.4	85.8
	Percentage change from preceding month											
1968												
July	+0.7	+0.4	0	-0.2	+0.6	+1.0	+0.4	+0.5	+3.8	+4.9	---	---
August	+1.0	+1.0	+.1	0	+.9	+1.6	+1.2	+1.1	+2.2	+2.1	---	+194.6
September	+1.6	+1.2	(8/)	0	+.6	+1.7	+1.7	+1.8	+2.1	+6.8	---	+61.3
October	+.6	+1.1	+.2	0	+1.0	+1.9	+1.4	+1.3	-.3	-4.4	---	+3.4
November	+.9	+1.0	(9/)	0	+.7	+1.3	+1.3	+1.3	0	-.2	---	+2.4
December	+1.7	+1.5	(9/)	-.4	+.9	+2.0	+2.1	+2.0	+2.6	+3.6	---	+4.8
1969												
January	+1.7	+1.6	-.1	-.3	+1.3	+2.2	+2.2	+2.1	+3.1	+2.7	---	+71.8
February	+1.4	+1.8	0	-.3	+1.1	+2.3	+2.5	+2.0	-.4	-3.0	---	+149.0
March	+1.2	+1.3	+.2	+.1	+1.3	+1.9	+1.6	+1.5	+.3	-.2	---	+3.8
April	+.5	+.8	+.1	-.2	+1.4	+1.2	+.9	+.9	-1.6	-2.5	---	+10.3
May	(9/)	+.1	+.1	-.4	+1.3	+.5	0	+.1	+.3	-1.0	---	+3.3
June	(9/)	+.3	+.1	+.3	+1.0	+.7	+.3	+.3	-3.4	-3.6	---	+11.0
July	+.8	+.7	+.2	-.1	+1.0	+1.2	+.8	+.8	+1.6	+2.0	---	+12.3
	Percentage change from same month of preceding year											
1969												
July	+12.0	+12.9	+1.1	-1.2	+13.2	+20.4	+17.3	+16.3	+6.4	+2.1	---	---

1/ All data subject to revision.
2/ Includes recipients of nonmedical vendor payments other than those for institutional services in intermediate care facilities.
3/ Families with children receiving emergency assistance in form of money payments and/or medical vendor payments. Such emergency assistance to needy families with children authorized under title IV. Data not available for months prior to July 1969.
4/ Includes recipients of OAA, AB, or APTD for whom such payments are subject to Federal financial participation under approved State plans under titles I, X, XIV, or XVI and a few AFDC or GA recipients for whom such payments are made without Federal participation.
5/ Partly estimated. Does not include Idaho, Indiana, Kentucky, Nebraska, Nevada, and Puerto Rico; data not available.
6/ Includes as recipients the children and 1 or both parents or 1 caretaker relative other than a parent in families in which the requirements of such adults were considered in determining the amount of assistance.
7/ Does not include Illinois; data not available.
8/ Decrease of less than 0.05 percent.
9/ Increase of less than 0.05 percent.

Note: Beginning with the March 1969 release; the total in column 1 includes all recipients of money payments; previously it did not include recipients of general assistance. Column 2 is the total for all Federally aided programs; previously it included only the adult programs.

Table 4. Old-age assistance: Recipients of money payments and amount of payments, by State, July 1969[1]

/Excludes vendor payments for institutional services in intermediate care facilities and for medical care and recipients of only such payments/

State	Number of recipients	Payments to recipients		Percentage change from--			
		Total amount	Average	June 1969 in--		July 1968 in--	
				Number	Amount	Number	Amount
Total 2/.....	2,041,000	$144,738,000	$70.95	+0.2	+0.8	+1.1	+4.8
Ala.....	114,000	7,061,000	61.85	+.1	(3/)	+1.0	+5.4
Alaska 4/.....	1,500	136,000	90.70	-.3	+1.3	+2.8	+16.4
Ariz.....	11,900	790,000	66.45	+1.2	+21.1	-7.7	+16.1
Ark. 4/.....	60,600	3,236,000	53.45	-.2	-.5	-2.0	-4.3
Calif.....	310,000	32,723,000	105.65	+.5	+.1	+5.6	+9.8
Colo. 2/.....	38,100	2,967,000	77.85	+.2	-.2	-1.6	-1.2
Conn.....	7,700	697,000	90.35	+.5	+.2	+4.1	+2.3
Del.....	1,900	108,000	57.60	+1.6	+.6	+.9	-2.8
D. C.....	2,400	182,000	74.95	+.8	(5/)	+5.9	+6.3
Fla. 4/.....	69,600	3,385,000	48.65	+.2	-.1	-1.4	-1.6
Ga. 4/.....	91,500	4,637,000	50.65	+.9	+.6	+3.5	+1.0
Guam.....	300	15,200	51.35	+1.0	+1.0	+20.8	+18.4
Hawaii 4/.....	2,000	196,000	96.65	+2.1	+9.6	+7.7	+25.2
Idaho.....	3,200	209,000	64.90	-.8	-.8	-7.0	-5.8
Ill. 4/.....	37,500	2,550,000	68.00	+.1	+5.5	-.7	+10.7
Ind.....	16,800	790,000	46.90	-.4	-.5	-4.3	-3.9
Iowa.....	23,600	2,558,000	108.60	+.6	+1.3	+.4	+7.1
Kans. 4/.....	14,300	1,123,000	78.80	+.1	+.6	-11.7	-21.0
Ky. 4/.....	64,500	3,463,000	53.70	+.4	+.5	+5.7	+6.3
La.....	120,000	8,311,000	69.40	-.3	-.1	-2.0	-2.6
Maine 4/.....	10,800	612,000	56.60	+6.3	+.6	+7.1	+12.8
Md. 4/.....	8,300	538,000	64.95	-4.1	-16.1	+7.0	+14.7
Mass.....	49,600	4,408,000	88.95	-.1	-.8	+3.2	+13.2
Mich.....	37,400	2,712,000	72.55	-.2	+.2	-1.9	+5.3
Minn.....	22,200	1,475,000	66.45	-.6	+.5	-7.0	-2.0
Miss.....	72,400	2,880,000	39.80	+.7	+1.7	+1.6	+12.4
Mo.....	90,200	6,715,000	74.40	+.2	+3.3	-1.7	+1.1
Mont.....	3,600	229,000	63.45	+.5	+.7	-2.0	-2.9
Nebr. 4/.....	8,000	462,000	57.90	+.3	+.8	-3.4	-.7
Nev.....	3,100	213,000	68.50	+3.6	+3.4	+19.9	+9.0
N. H.....	4,200	488,000	116.95	-.1	+.5	+1.0	+10.4
N. J.....	14,800	1,181,000	79.60	+.8	+.6	+5.8	+15.3
N. Mex. 4/.....	9,200	510,000	55.55	+.1	(3/)	-4.4	-2.0
N. Y. 4/.....	86,700	8,140,000	93.90	+.3	+4.8	+12.7	+12.0
N. C. 4/.....	38,100	2,715,000	71.20	+.2	+.7	+1.9	+7.7
N. Dak. 4/.....	3,900	307,000	79.25	-.6	+.5	-5.7	-1.2
Ohio.....	58,600	3,490,000	59.60	-.4	-.2	-4.7	-6.7
Okla. 4/.....	75,500	5,270,000	69.80	+.2	-.1	-2.7	-5.0
Oreg.....	7,300	469,000	64.15	+1.1	+2.8	-15.1	+5.8
Pa.....	45,300	3,781,000	83.45	+.9	+.6	+5.9	+25.3
P. R. 4/.....	21,300	265,000	12.45	+.2	+.1	-2.7	+16.0
R. I. 4/.....	3,700	183,000	49.35	+.4	-.3	-9.7	-1.1
S. C.....	18,900	853,000	45.10	-.3	-.3	-3.9	-3.0
S. Dak.....	4,500	263,000	57.85	-1.2	-7.1	-7.4	-13.6
Tenn.....	49,900	2,541,000	50.90	+.3	(5/)	-.9	+2.5
Tex.....	228,000	13,536,000	59.40	(5/)	+.2	-.2	-2.3
Utah.....	4,300	196,000	46.00	-1.8	+2.1	+4.7	-2.5
Vt. 4/.....	4,300	310,000	71.85	+.6	+1.0	+1.2	+6.8
V. I.....	360	13,800	37.90	-1.1	-1.9	-1.4	-3.0
Va.....	11,100	675,000	61.00	-1.0	-8.7	+2.0	+11.8
Wash.....	23,000	1,553,000	67.55	+.2	+7.8	+1.9	+2.4
W. Va.....	11,200	864,000	76.80	+.6	+15.6	-.2	+22.7
Wis.....	18,200	1,645,000	90.55	-.4	+1.9	+11.8	+61.8
Wyo.....	1,800	107,000	60.25	-10.1	-32.8	-13.2	-32.6

1/ All data subject to revision. Data include nonmedical vendor payments other than those for institutional services in intermediate care facilities.
2/ Includes 3,600 recipients aged 60-64 in Colorado and payments of $326,000 to these recipients. Such payments were made without Federal participation.
3/ Increase of less than 0.05 percent.
4/ Represents aid to the aged under program for aid to the aged, blind, or disabled, or for such aid and medical assistance for the aged.
5/ Decrease of less than 0.05 percent.

Table 5. Aid to the blind: Recipients of money payments and amount of payments, by State, July 1969[1]

[Excludes vendor payments for institutional services in intermediate care facilities and for medical care and recipients of only such payments]

State	Number of recipients	Payments to recipients		Percentage change from--			
		Total amount	Average	June 1969 in--		July 1968 in--	
				Number	Amount	Number	Amount
Total 2/ 3/.....	80,100	$7,631,000	$95.30	-0.1	-0.2	-1.2	+3.0
Ala.....	1,900	136,000	70.15	0	-.1	+2.3	+2.4
Alaska 4/.....	93	11,200	120.60	(5/)	(5/)	(5/)	(5/)
Ariz.....	550	45,200	81.90	-1.4	+10.1	-14.2	-.1
Ark. 4/.....	1,800	122,000	67.45	-.3	-.3	-2.1	-4.8
Calif. 2/.....	13,000	1,891,000	145.80	+.3	-.1	+3.4	+8.5
Colo.....	200	15,800	78.35	+1.0	-2.4	-3.4	+3.7
Conn.....	240	22,300	93.50	+1.3	+1.7	-2.1	+8.6
Del.....	360	33,500	92.40	+.8	+4.8	+6.8	+10.9
D. C.....	200	17,400	87.65	+2.6	+4.9	+9.4	+6.7
Fla. 4/.....	2,300	149,000	64.20	-.9	-.6	-4.3	-4.1
Ga. 4/.....	3,200	200,000	62.20	+.3	+.2	+2.1	+.9
Guam.....	7	440	(5/)	(5/)	(5/)	(5/)	(5/)
Hawaii 4/.....	67	7,500	112.35	(5/)	(5/)	(5/)	(5/)
Idaho.....	110	8,400	79.50	-1.9	-1.0	0	+2.8
Ill. 4/.....	1,700	153,000	89.10	-.5	+2.3	-3.5	+6.8
Ind.....	1,400	90,200	64.70	-4.8	-.4	-3.1	-3.3
Iowa.....	1,000	128,000	123.25	-.6	+8.9	-.6	+14.0
Kans. 4/.....	370	30,100	81.95	-.8	-1.3	-8.2	-15.2
Ky. 4/.....	2,100	148,000	69.85	-1.3	-.9	-19.2	-19.8
La.....	2,400	185,000	76.80	-.7	-.5	-2.6	-3.2
Maine 4/.....	220	18,300	84.00	+1.4	+1.0	+3.8	+15.8
Md. 4/.....	340	30,200	87.45	+2.7	+1.5	+.6	+6.3
Mass.....	2,600	378,000	148.15	(6/)	(7/)	+3.7	+22.0
Mich.....	1,400	132,000	95.15	-.1	+1.0	-3.5	+3.8
Minn.....	800	65,300	81.60	-.1	+1.1	-2.0	-.7
Miss.....	2,200	109,000	49.95	-.4	+.5	-5.3	+4.4
Mo. 2/.....	3,900	336,000	86.95	+.5	+.9	-.4	-.4
Mont.....	170	15,100	88.75	+4.3	+15.3	+5.6	+17.3
Nebr. 4/.....	340	29,400	85.95	-.9	-.1	-2.6	-1.7
Nev.....	180	16,200	92.60	-.6	+2.3	+14.4	+2.3
N. H.....	240	27,300	115.55	+1.3	+.3	+.4	+1.6
N. J.....	910	88,700	97.65	+.1	-1.2	+2.1	+11.7
N. Mex. 4/.....	370	27,200	74.45	-.8	-1.6	+.5	+.8
N. Y. 4/.....	3,400	395,000	115.55	-1.7	-5.7	+4.8	-.6
N. C. 4/.....	4,700	393,000	84.15	+.3	-6.8	+.8	+6.6
N. Dak. 4/.....	84	8,200	98.20	(5/)	(5/)	(5/)	(5/)
Ohio.....	2,700	199,000	72.85	(6/)	-.2	-3.0	-2.8
Okla. 4/.....	1,400	138,000	101.95	-.1	-.8	-8.1	-10.4
Oreg.....	470	52,400	111.30	-.2	+19.0	-6.0	+20.3
Pa. 3/.....	8,900	983,000	110.45	+.3	+.5	-3.9	-2.0
P. R. 4/.....	750	9,400	12.50	-1.2	-1.3	-5.2	+12.9
R. I. 4/.....	120	8,200	70.75	-.9	-.4	+2.7	+9.6
S. C.....	1,900	109,000	58.00	+.1	+.1	+.1	+.6
S. Dak.....	110	9,000	80.35	-1.8	-6.5	-2.6	-10.1
Tenn.....	1,800	121,000	68.00	+.3	+2.2	-.7	+.2
Tex.....	4,100	294,000	72.05	-.3	-.4	-1.7	-2.7
Utah.....	160	11,100	70.30	+9.7	+28.2	+14.5	+37.7
Vt. 4/.....	100	9,600	91.20	0	+1.8	0	+3.9
V. I.....	7	270	(5/)	(5/)	(5/)	(5/)	(5/)
Va.....	1,000	81,000	77.40	-1.3	-6.5	-3.3	+.4
Wash.....	460	44,000	95.85	-.4	+9.2	-.6	+5.4
W. Va.....	570	38,900	68.20	+.5	+14.1	-4.4	+14.7
Wis.....	650	56,700	86.70	+.6	+1.0	+13.3	+24.9
Wyo.....	38	2,600	(5/)	(5/)	(5/)	(5/)	(5/)

1/ All data subject to revision. Data include nonmedical vendor payments other than those for institutional services in intermediate care facilities.
2/ Data include recipients of payments made without Federal participation and payments to these recipients as follows: California, $45,400 to 240 recipients and Missouri, $45,700 to 510 recipients.
3/ Does not include $600,000 to an estimated 7,800 recipients under State blind pension program in Pennsylvania administered under State Law without Federal participation.
4/ Represents aid to the blind under program for aid to the aged, blind, or disabled, or for such aid and medical assistance for the aged.
5/ Average payment not computed on base of fewer than 50 recipients; percentage change on fewer than 100 recipients.
6/ Decrease of less than 0.05 percent.
7/ Increase of less than 0.05 percent.

Table 6. Aid to the permanently and totally disabled: Recipients of money payments and amount of payments, by State, July 1969[1]

[Excludes vendor payments for institutional services in intermediate care facilities and for medical care and recipients of only such payments]

State	Number of recipients	Payments to recipients		Percentage change from--			
		Total amount	Average	June 1969 in--		July 1968 in--	
				Number	Amount	Number	Amount
Total.....	763,000	$65,801,000	$86.25	+1.0	+1.8	+13.2	+19.4
Ala.....	17,000	851,000	50.00	+.4	+.4	+7.3	+7.9
Alaska 2/.....	620	72,000	115.55	+1.0	+2.0	+33.7	+53.4
Ariz.....	6,300	409,000	65.35	+.7	+.6	+3.0	+2.2
Ark. 2/.....	11,300	680,000	60.45	+.3	+.2	-2.0	-3.9
Calif.....	151,000	18,472,000	121.95	+1.9	+1.0	+20.2	+23.6
Colo.....	7,700	571,000	74.45	+.4	+2.3	+6.5	+17.3
Conn.....	6,000	653,000	108.75	-.2	-.4	+14.1	+13.0
Del.....	1,300	126,000	97.55	+.5	+1.7	+15.8	+24.8
D. C.....	4,900	434,000	88.80	+1.6	+1.9	+14.3	+17.4
Fla. 2/.....	20,500	1,259,000	61.30	+.5	+.4	+.9	+1.1
Ga. 2/.....	31,500	1,906,000	60.60	+1.6	+1.6	+6.6	+5.3
Guam 3/.....	49	2,700	(4/)	---	---	---	---
Hawaii 2/.....	1,700	219,000	131.00	+2.1	+8.3	+6.6	+26.2
Idaho.....	2,800	214,000	75.95	-.8	-1.0	+4.6	+6.0
Ill. 2/.....	37,100	3,374,000	90.95	+.7	+5.5	+10.7	+22.8
Ind.....	4,500	231,000	51.75	+1.9	+2.4	+37.4	+40.4
Iowa.....	2,700	365,000	134.15	+1.9	+2.2	+14.9	+19.6
Kans. 2/.....	5,700	537,000	94.60	+1.0	+1.3	+.7	-19.4
Ky. 2/.....	15,100	1,058,000	69.90	+1.3	+1.2	-1.6	-2.7
La.....	21,900	1,173,000	53.60	-.7	-.5	-2.3	-2.3
Maine 2/.....	3,400	279,000	82.90	+5.8	+2.8	+23.8	+34.5
Md. 2/.....	14,900	1,263,000	84.60	+.4	+1.0	+10.5	+19.2
Mass.....	15,500	1,668,000	107.50	+.7	+1.3	+3.9	+16.9
Mich.....	23,300	2,204,000	94.65	+1.9	+2.7	+18.0	+28.2
Minn.....	9,100	810,000	88.95	+.8	+1.2	+8.2	+19.2
Miss.....	21,600	1,057,000	49.00	+.2	+.7	-.9	+9.2
Mo.....	18,000	1,370,000	76.20	-.5	+2.4	+3.8	+7.5
Mont.....	1,900	145,000	77.40	+2.0	+1.7	+17.6	+17.4
Nebr. 2/.....	3,800	250,000	66.55	+2.4	+1.7	+9.7	+5.7
N. H.....	760	78,900	103.25	+1.3	+.9	+9.0	+8.9
N. J.....	11,400	1,157,000	101.30	+.9	(5/)	+14.3	+28.4
N. Mex. 2/.....	7,200	508,000	70.20	+1.6	+1.7	+21.3	+23.4
N. Y. 2/.....	62,700	6,662,000	106.30	+1.1	+3.5	+46.6	+42.4
N. C. 2/.....	25,300	1,900,000	75.05	+.3	+.6	+7.9	+11.6
N. Dak. 2/.....	2,000	175,000	88.15	-.2	+.1	+5.4	+8.8
Ohio.....	29,100	2,099,000	72.15	+1.4	+1.4	+16.9	+16.6
Okla. 2/.....	19,800	1,841,000	93.05	+.6	+.3	+1.4	(6/)
Oreg.....	4,700	434,000	92.75	-1.6	+3.4	-7.9	+12.9
Pa.....	26,500	2,396,000	90.40	+.1	+1.0	+2.1	+26.4
P. R. 2/.....	13,800	174,000	12.55	+3.6	+3.4	+10.7	+31.7
R. I. 2/.....	3,600	280,000	78.05	+.1	+.8	+2.8	+9.5
S. C.....	9,700	500,000	51.60	+.3	+.3	+6.3	+7.1
S. Dak.....	1,400	86,300	62.10	-1.3	-5.8	+5.8	-.4
Tenn.....	21,200	1,428,000	67.25	+1.1	+4.3	+13.2	+16.2
Tex.....	20,600	1,220,000	59.10	+1.4	+1.2	+33.5	+28.8
Utah.....	5,300	337,000	63.75	+1.9	+6.7	+37.9	+51.2
Vt. 2/.....	1,700	156,000	90.55	-.6	+.8	+13.2	+22.7
V. I.....	69	2,800	40.90	(4/)	(4/)	(4/)	(4/)
Va.....	7,200	516,000	71.70	-2.0	-11.2	+1.1	+8.5
Wash.....	13,000	1,172,000	90.50	+.5	+9.1	+35.8	+41.1
W. Va.....	6,900	446,000	64.60	+3.7	+18.6	+11.2	+30.3
Wis.....	6,600	529,000	79.95	+.8	+8.7	+15.0	+43.4
Wyo.....	780	49,600	63.65	-4.4	-17.1	-7.4	-17.7

1/ All data subject to revision. Data include nonmedical vendor payments other than those for institutional services in intermediate care facilities.
2/ Represents aid to the permanently and totally disabled under program for aid to the aged, blind, or disabled, or for such aid and medical assistance for the aged.
3/ Represents data for June; July data not reported.
4/ Average payment not computed on base of fewer than 50 recipients; percentage change on fewer than 100 recipients.
5/ Increase of less than 0.05 percent.
6/ Decrease of less than 0.05 percent.

Table 7. Aid to families with dependent children: Recipients of money payments and amount of payments, by State, July 1969[1]

/Excludes vendor payments for institutional services in intermediate care facilities and for medical care and cases receiving only such payments/

State	Number of families	Number of recipients		Payments to recipients			Percentage change from--			
					Average per--		June 1969 in--		July 1968 in--	
		Total 2/	Children	Total amount	Family	Recipient	Number of recipients	Amount	Number of recipients	Amount
Total 2/...	1,681,000	6,613,000	4,917,000	$293,003,000	$174.25	$44.30	+0.8	+1.9	+17.3	+23.4
Ala.	26,100	109,000	85,100	1,656,000	63.35	15.15	+3.6	+.5	+17.8	+17.7
Alaska	2,200	7,000	5,400	337,000	155.95	48.05	+.7	+1.1	+22.2	+53.3
Ariz.	10,900	45,600	34,700	1,582,000	145.60	34.70	+.5	+22.0	+6.5	+28.3
Ark.	10,100	40,200	30,500	794,000	78.50	19.75	-1.4	-.4	+6.0	+10.1
Calif. 3/	270,000	1,005,000	721,000	50,421,000	186.60	50.20	+.1	+.7	+23.5	+32.9
Colo. 3/	15,700	57,700	43,700	2,343,000	148.80	40.60	+.8	+3.6	+6.7	+8.5
Conn.	20,600	78,100	58,200	4,625,000	224.65	59.25	-.4	-1.7	+17.2	+22.5
Del. 3/	4,700	18,400	13,800	606,000	128.05	33.00	+1.3	+1.4	+6.7	+9.3
D. C.	8,000	34,000	26,800	1,443,000	180.35	42.40	+3.2	+4.6	+27.1	+37.6
Fla.	46,300	181,000	143,000	4,405,000	95.20	24.40	+1.4	+18.6	+18.8	+37.9
Ga.	44,700	171,000	130,000	4,756,000	106.40	27.85	+6.1	+20.4	+45.5	+63.2
Guam	320	1,500	1,300	52,800	167.65	34.20	+1.1	+2.7	+30.6	+11.4
Hawaii 3/	5,500	22,000	16,000	1,190,000	216.60	54.20	+2.7	+16.5	+11.7	+21.7
Idaho	3,500	13,100	9,400	626,000	177.95	48.00	+.7	+1.3	+7.8	+10.6
Ill. 3/	78,100	338,000	262,000	17,002,000	217.75	50.35	+.2	+6.0	+14.4	+31.4
Ind.	14,400	59,000	44,400	1,915,000	133.10	32.45	-1.8	-.7	+10.7	+11.4
Iowa	15,400	59,000	42,900	3,000,000	194.25	50.85	+.7	+.7	+12.1	+15.8
Kans. 3/	12,000	47,600	36,700	2,272,000	189.15	47.70	+1.5	+2.6	+15.4	+21.7
Ky.	32,100	124,000	89,200	3,618,000	112.55	29.30	+.4	+.6	+11.9	+15.0
La.	42,000	180,000	139,500	3,907,000	93.05	21.70	+1.2	-8.9	+25.8	+15.2
Maine 3/	8,200	29,700	22,000	933,000	114.20	31.45	+1.4	-2.1	+32.8	+40.1
Md. 3/	30,900	119,000	91,800	4,908,000	158.70	41.15	+1.2	+6.3	+6.9	+11.5
Mass. 3/	50,300	184,000	135,000	11,580,000	230.10	62.95	+1.6	+.6	+22.4	+32.9
Mich. 3/	54,900	220,000	165,000	11,263,000	205.05	51.20	+1.5	+9.5	+11.6	+26.7
Minn.	19,100	66,800	51,300	3,918,000	205.45	58.65	+1.0	+5.5	+8.2	+16.3
Miss.	27,100	108,000	88,300	1,137,000	41.90	10.55	+1.6	+5.2	+4.7	+30.0
Mo. 3/	31,000	125,000	95,800	3,464,000	111.65	27.65	+.6	+4.0	+8.4	+11.2
Mont.	3,200	11,700	8,900	437,000	138.55	37.45	+1.9	+1.8	+18.7	+19.8
Nebr. 3/	6,900	26,600	20,400	1,006,000	146.00	37.90	+.1	+.7	+9.3	+12.0
Nev.	3,000	9,900	7,600	319,000	106.90	32.20	+5.0	+4.4	+13.3	+19.7
N. H.	1,900	7,800	5,800	341,000	176.05	43.80	+.8	+.3	+24.3	+25.6
N. J. 3/	56,200	225,000	167,000	14,565,000	259.35	64.65	+2.1	-.6	+41.2	+56.6
N. Mex.	11,700	45,300	34,500	1,430,000	122.05	31.55	+1.1	+1.9	+9.0	+10.8
N. Y. 3/	261,000	1,007,000	726,000	64,138,000	245.95	63.70	+.1	-2.8	+15.2	+3.4
N. C.	28,400	113,000	85,200	3,335,000	117.25	29.55	-1.5	+1.9	+8.8	+17.8
N. Dak.	2,600	10,200	7,800	516,000	194.70	50.80	+.6	+2.2	+4.0	+10.2
Ohio 3/	62,100	248,000	185,000	9,858,000	158.70	39.80	-.1	+.4	+7.4	+13.7
Okla. 3/	24,000	89,900	67,500	3,086,000	128.50	34.35	+1.1	+1.7	+1.6	+1.1
Oreg. 3/	15,000	54,400	38,600	2,574,000	171.50	47.35	+4.6	+15.1	+43.5	+67.5
Pa. 3/	94,100	382,000	278,000	20,138,000	213.95	52.70	+1.6	+2.9	+23.1	+66.0
P. R.	40,700	201,000	149,000	1,684,000	41.35	8.40	+1.8	+5.6	+14.9	+35.0
R. I. 3/	9,400	35,600	25,900	1,725,000	184.40	48.40	+1.1	+1.9	+15.7	+18.8
S. C.	10,900	42,300	33,800	780,000	71.50	18.45	+.2	+.1	+37.5	+37.6
S. Dak.	4,100	14,900	11,200	680,000	167.75	45.50	-.1	-1.0	+8.9	+11.9
Tenn.	29,500	112,000	86,600	3,005,000	101.95	26.70	-1.1	+.8	+12.1	+14.7
Tex.	36,900	165,000	127,000	3,099,000	83.95	18.75	-.3	+10.3	+18.3	+8.2
Utah 3/	7,900	29,900	20,200	1,182,000	149.40	39.55	+.5	+4.8	+13.6	+15.9
Vt. 3/	3,100	11,300	8,200	594,000	189.80	52.45	-1.3	+3.6	+20.5	+34.3
V. I.	420	1,700	1,400	48,300	113.55	28.40	+.4	+.4	+7.3	+2.2
Va.	18,000	72,200	55,400	2,963,000	164.75	41.00	+1.6	+8.4	+19.2	+57.0
Wash. 3/	23,500	82,300	58,300	4,648,000	198.00	56.50	+3.2	+20.9	+24.9	+45.1
W. Va. 3/	19,600	84,500	59,000	2,295,000	116.90	27.15	+1.6	+5.0	-2.1	+3.7
Wis. 3/	21,800	82,500	62,100	4,635,000	212.20	56.15	-.1	+.2	+17.6	+27.5
Wyo.	1,200	4,500	3,400	169,000	139.30	38.00	-1.2	-1.3	+.3	-.4

1/ All data subject to revision. Data include nonmedical vendor payments other than those for institutional services in intermediate care facilities.

2/ Includes as recipients the children and 1 or both parents or 1 caretaker relative other than a parent in families in which the requirements of such adults were considered in determining the amount of assistance.

3/ Includes data on unemployed-parent segment; see table 8.

Table 8. Aid to families with dependent children, unemployed-parent segment: Recipients of money payments and amount of payments, by State, July 1969[1]

/Excludes vendor payments for institutional services in intermediate care facilities and for medical care and cases receiving only such payments/

State	Number of families	Number of recipients		Payments to recipients			Percentage change from--			
					Average per--		June 1969 in--		July 1968 in--	
		Total 2/	Children	Total	Family	Recipient	Number of recipients	Amount	Number of recipients	Amount
Total.....	61,500	335,000	217,000	$15,335,000	$249.55	$45.70	-5.1	-3.3	+1.9	+9.3
Calif.....	25,100	133,000	85,200	5,678,000	225.75	42.80	-5.7	-4.0	+11.1	+24.9
Colo.....	950	4,600	3,100	200,000	210.45	43.10	-2.8	(3/)	+3.1	+6.9
Del.....	54	380	270	10,700	197.65	28.45	+1.4	+4.6	-58.3	-62.2
Hawaii.....	230	1,300	880	69,400	307.30	52.00	+.5	+16.7	-25.0	-5.3
Ill.....	3,000	18,100	12,200	865,000	289.65	47.85	-7.3	-.7	-8.1	+8.2
Kans.....	220	1,300	890	57,700	262.25	43.40	+5.5	-.1	-20.4	-13.0
Maine.....	36	240	170	7,300	(4/)	30.85	+3.0	+6.5	(5/)	(5/)
Md.....	180	1,000	650	37,000	204.25	37.10	+11.1	+15.4	-4.8	+3.5
Mass.....	780	4,400	2,900	247,000	316.95	56.60	+.2	+.4	+16.0	+23.5
Mich.....	1,300	7,700	5,200	359,000	280.70	46.55	-1.2	+9.4	-26.3	-16.5
Mo.....	91	590	410	16,600	182.30	28.00	+1.2	+.9	(5/)	(5/)
Nebr.....	57	360	260	11,600	204.10	32.05	-2.9	-3.6	-25.8	-29.3
N. J.....	3,100	17,500	11,700	1,110,000	362.95	63.55	+4.7	-6.8	(5/)	(5/)
N. Y.....	13,300	72,700	46,700	3,779,000	284.70	51.95	-7.4	-7.2	-8.6	-22.4
Ohio.....	1,800	10,900	7,300	419,000	229.95	38.30	-6.2	-6.2	-31.6	-26.3
Okla.....	290	1,800	1,200	56,900	195.60	32.30	-21.3	-29.1	-44.2	-44.9
Oreg.....	1,700	8,600	5,300	381,000	227.25	44.45	-4.7	+9.3	+139.3	+171.3
Pa.....	2,200	12,300	7,900	628,000	283.15	51.25	-6.0	+9.2	-27.7	+19.0
R. I.....	300	1,700	1,100	66,800	226.45	40.45	-3.1	+2.5	-4.2	-2.2
Utah.....	880	4,900	3,000	191,000	216.80	38.75	-6.9	+2.8	-9.0	+15.1
Vt.....	54	310	210	14,500	269.30	46.30	-16.5	-17.2	(4/)	(4/)
Wash.....	780	3,500	2,100	197,000	252.50	55.70	-3.4	+21.3	+63.3	+113.0
W. Va.....	4,200	23,500	15,400	671,000	160.90	28.55	+2.7	+6.4	-23.2	-16.2
Wis.....	920	5,100	3,400	260,000	283.45	51.00	-2.1	-2.3	+7.1	+19.1

1/ Data for this segment of the program, shown separately here, are included in data for the total program. All data subject to revision. Data include nonmedical vendor payments other than those for institutional services in intermediate care facilities.
2/ Includes as recipients the children and 1 or both parents or 1 caretaker relative other than a parent in families in which the requirements of such adults were considered in determining the amount of assistance.
3/ Increase of less than 0.05 percent.
4/ Average payment not computed on base of fewer than 50 families; percentage change on fewer than 100 recipients.
5/ Program not in operation in July 1968.

Table 9. General assistance: Recipients of money payments and amount of payments, by State, July 1969[1]

[Excludes vendor payments for institutional services in intermediate care facilities and for medical care and cases receiving only such payments]

State	Number of--		Payment to recipients			Percentage change from--			
				Average per--		June 1969 in--		July 1968 in--	
	Cases	Recipients	Total amount	Cases	Recipient	Number of recipients	Amount	Number of recipients	Amount
Total 2/	390,000	784,000	$37,834,000	$96.90	$48.25	+2.0	+3.2	+2.1	+7.4
Ala.	70	70	970	13.90	13.90	(3/)	(3/)	(3/)	(3/)
Alaska	200	650	15,200	75.60	23.50	+164.8	+157.4	+215.1	+51.3
Ariz.	1,800	3,600	96,200	52.40	26.75	-28.8	-13.3	-20.8	+10.4
Ark.	200	600	2,900	14.65	4.85	-13.4	-4.5	-29.8	-20.4
Calif.	40,600	63,000	2,985,000	73.60	47.40	-3.0	-1.5	+10.0	+22.9
Colo.	920	2,600	42,700	46.20	16.60	-2.4	+7.0	-24.5	-9.8
Conn. 4/	7,000	22,000	716,000	102.15	32.60	+8.4	+5.4	+31.5	+42.8
Del.	2,200	4,800	132,000	61.05	27.55	-5.4	-4.3	+17.3	+16.1
D. C.	1,500	1,600	136,000	90.60	83.50	+2.4	+4.6	+56.7	+65.8
Fla. 4/	7,800	19,400	254,000	---	---	---	---	---	---
Ga. 5/	1,800	3,900	68,500	38.15	17.45	---	---	---	---
Guam	73	100	4,400	60.50	44.15	0	-4.0	(3/)	(3/)
Hawaii	1,900	4,100	248,000	133.00	60.85	+6.2	+20.8	+43.1	+45.3
Ill.	29,500	61,800	3,140,000	106.30	50.75	+6.4	+7.5	+12.5	+29.4
Iowa 4/	3,200	8,300	151,000	---	---	---	---	---	---
Kans.	3,200	6,200	291,000	92.30	46.80	+2.2	-1.2	+6.0	+18.6
La.	7,100	7,800	370,000	51.75	47.60	+2.0	+2.5	+8.5	+10.0
Maine	2,000	6,600	82,100	41.20	12.45	+11.0	+10.5	+4.1	+4.3
Md.	6,000	6,900	526,000	87.85	76.35	+4.4	+5.3	-10.3	-4.2
Mass.	14,100	26,000	1,541,000	109.25	59.35	+4.6	+5.4	+24.3	+53.2
Mich.	24,000	73,900	2,653,000	110.45	35.90	+8.3	+11.6	+5.3	+8.5
Minn.	6,600	18,400	615,000	93.35	33.45	+5.6	+1.0	-3.4	-1.7
Miss.	1,300	1,500	21,700	17.15	14.30	-.5	-4.8	-6.1	-11.3
Mo.	10,500	12,700	703,000	66.75	55.20	-.7	+3.0	+1.9	+8.9
Mont.	740	2,100	33,900	45.90	16.20	-4.1	-11.0	-22.3	-35.9
N. H.	700	2,100	50,000	71.35	24.10	+2.1	+.6	+1.5	+12.6
N. J. 6/	7,700	9,000	981,000	127.60	108.90	+2.8	+4.9	-75.2	-33.9
N. Mex.	120	180	5,600	47.70	30.40	-3.6	+10.7	-66.8	-40.2
N. Y.	96,400	197,000	12,015,000	124.70	61.00	-3.4	-1.8	-4.0	-15.2
N. C.	1,500	3,600	43,500	28.65	12.15	+10.1	+8.4	-8.0	+.8
N. Dak.	150	550	6,900	47.30	12.55	-17.8	-24.2	-19.7	-22.5
Ohio	21,500	55,700	2,118,000	98.30	38.00	+10.5	+10.8	-14.1	-11.0
Okla.	1,000	2,300	18,400	18.15	8.10	+3.9	+4.6	---	-10.7
Oreg.	2,400	5,200	163,000	68.15	31.45	+3.6	+3.3	---	+33.1
Pa.	48,600	73,700	5,501,000	113.10	74.65	+4.2	+6.6	+65.1	+112.8
R. I.	5/ 3,400	5/ 10,000	324,000	---	---	---	+27.5	---	+8.3
S. C.	1,100	1,300	44,200	38.80	33.25	+.6	+1.1	+51.7	+52.3
S. Dak.	240	800	7,200	29.85	8.95	+18.6	-3.9	+8.4	-24.1
Tenn.	1,800	5,200	53,200	29.50	10.15	+13.9	+11.1	+54.9	+27.4
Tex. 4/	7,700	(7/)	276,000	---	---	---	---	---	---
Utah	1,200	1,400	92,200	74.15	63.90	+10.7	-3.5	+3.4	-6.9
Vt. 4/	400	(7/)	12,000	---	---	---	---	---	---
V. I.	170	190	7,400	42.65	38.25	+1.0	-1.1	+15.5	+14.5
Va.	4,700	10,300	311,000	66.80	30.35	-10.5	-6.5	+40.7	+45.2
Wash.	7,400	12,900	688,000	92.80	53.40	+20.5	+21.5	-11.9	-8.4
W. Va.	2,700	4,000	127,000	47.25	32.15	+5.7	+2.9	+27.2	+53.8
Wis.	6,100	14,900	484,000	79.75	32.45	+.9	-6.9	+9.5	+22.4
Wyo.	150	390	7,800	51.05	20.25	-2.3	-13.7	-29.2	-39.8

1/ All data subject to revision. Data include nonmedical vendor payments other than those for institutional services in intermediate care facilities.

2/ Partly estimated; does not represent sum of State figures because totals exclude for New Jersey an estimated number of cases and persons receiving only medical care, hospitalization, and/or burial and payments for such services; recipient count includes an estimate for States not reporting such data. Excludes Idaho, Indiana, Kentucky, Nebraska, Nevada, and Puerto Rico; data not available.

3/ Percentage change not computed on base of fewer than 100 recipients.

4/ Estimated.

5/ Data for June; July data not reported.

6/ Includes an unknown number of cases and persons receiving only medical care, hospitalization, and/or burial and payments for such services.

7/ Data not available.

Table 10. Emergency Assistance: Families receiving assistance and amount of payments, by State, July 1969[1]

State	Number of families			Amount of assistance payments			
	Total	AFDC money payment cases	Other	Total		Maintenance	Medical care
				Amount	Average per family		
Total 2/.....	6,400	3,400	2,200	$757,000	$118.00	$473,000	$41,200
Alaska.....	68	(3/)	(3/)	5,400	78.75	3,600	1,800
Ark.....	76	13	63	1,800	23.40	1,700	82
Kans.....	31	2	29	2,800	(4/)	2,800	---
Md.....	1,600	1,600	---	215,000	130.70	(3/)	(3/)
Mass.....	480	(3/)	(3/)	69,900	146.90	65,300	4,600
Mich.....	750	630	130	96,800	128.35	69,300	27,500
Nebr.....	110	(3/)	(3/)	10,100	93.85	9,900	220
N. Mex.....	13	---	13	960	(4/)	---	960
N. Y.....	(3/)	(3/)	(3/)	(3/)	---	(3/)	(3/)
Okla.....	180	(3/)	(3/)	27,600	151.50	(3/)	(3/)
Oreg.....	740	73	670	99,600	134.25	93,600	6,000
R. I.....	700	670	26	88,300	125.60	88,300	---
Wash.....	1,300	180	1,100	101,000	79.20	101,000	---
Wis.....	210	210	6	31,700	149.00	31,700	---
Wyo.....	130	---	130	6,100	46.55	6,000	60

1/ All data subject to revision. Such emergency assistance authorized to needy families with children under title IV.
2/ Data incomplete; see footnote 3.
3/ Data not available.
4/ Average payment not computed on base of fewer than 50 families.

Table 11. Institutional services in intermediate care facilities under old-age assistance,

Table 11. Institutional services in intermediate care facilities under old-age assistance, aid to the blind, and aid to the permanently and totally disabled: Recipients of such services and amount of payments, by State, July 1969[1]

State	Total, all programs 2/			Old-age assistance		
	Number of recipients	Payments for recipients		Number of recipients	Payments for recipients	
		Total amount	Average		Total amount	Average
Total 3/.....	85,800	$19,835,000	$231.05	70,900	$16,601,000	$234.30
Alaska.....	6	2,200	(4/)	2	740	(4/)
Colorado.....	500	77,800	157.15	300	46,900	157.75
District of Columbia....	3,300	798,000	240.85	2,500	607,000	243.45
Georgia.....	450	75,300	165.90	390	64,500	163.75
Illinois.....	14,400	3,107,000	215.60	11,600	2,459,000	212.25
Kansas.....	3,200	619,000	190.85	2,400	454,000	187.15
Louisiana.....	240	28,400	116.70	200	23,000	114.90
Maine.....	2,400	567,000	232.25	2,200	509,000	230.80
Maryland.....	(3/)	(3/)	---	(3/)	(3/)	---
Massachusetts.....	7,100	1,961,000	276.55	5,900	1,698,000	289.85
Michigan.....	4,800	1,693,000	350.80	4,000	1,398,000	345.20
Nebraska.....	5,100	909,000	178.70	5/ 3,400	5/ 616,000	5/ 178.70
Nevada.....	28	7,800	(4/)	28	7,800	(4/)
New Mexico.....	430	152,000	356.15	400	140,000	351.50
Ohio.....	9,700	2,048,000	211.85	8,000	1,662,000	208.75
Oregon.....	5,600	852,000	151.90	4,500	689,000	151.80
Rhode Island.....	1,600	222,000	139.60	1,100	158,000	139.30
South Carolina.....	140	24,500	181.80	92	16,500	178.95
South Dakota.....	1,700	330,000	197.90	1,500	292,000	196.15
Texas.....	20,100	5,494,000	273.10	18,900	5,175,000	273.20
Utah.....	1,600	246,000	152.35	860	127,000	147.25
Vermont.....	700	176,000	251.20	640	160,000	250.80
Virginia.....	360	67,500	188.10	280	51,700	184.10
Washington.....	1,900	301,000	159.15	1,200	179,000	152.95
Wyoming.....	430	77,100	179.70	360	67,100	185.30

1/ All data subject to revision. Data represent payments to vendors of institutional services in intermediate care facilities. Federal financial participation in such payments is limited to those in behalf of individuals who qualify for OAA, AB, or APTD under programs operated under State plans approved under titles I, X, XIV, or XVI.
2/ Includes a few payments of this type made without Federal participation for recipients of AFDC or GA.
3/ Data not reported for Maryland.
4/ Average payment not computed on base of fewer than 50 recipients.
5/ Estimated.

Table 12. Amount of vendor payments for medical care for recipients of public assistance, by program and State, July 1969[1]

State	Total	Percentage change from--		Medical assistance	Medical assistance for the aged	Old-age assistance	Aid to the blind	Aid to the permanently and totally disabled	Aid to families with dependent children	General assistance 2/
		June 1969	July 1968							
Total	$394,007,000	+3.6	+20.0	$367,337,000	$5,088,000	$8,966,000	$214,000	$3,364,000	$2,660,000	$6,378,000
Ala.	1,890,000	+2.6	+22.6	---	---	1,718,000	9,800	162,000	---	---
Alaska 3/	199,000	-21.7	+73.0	---	---	68,700	1,200	38,700	---	90,600
Ariz.	199,000	-1.0	+29.2	---	---	199,000	---	---	---	---
Ark. 3/	2,498,000	+23.9	+38.7	---	603,000	1,283,000	32,300	490,000	88,200	---
Calif.	63,886,000	-14.4	+28.5	63,886,000	---	---	---	---	---	---
Colo.	3,526,000	+8.2	+58.3	3,497,000	---	---	---	---	---	28,600
Conn.	9,202,000	+132.1	+73.1	9,078,000	---	---	---	---	---	124,000
Del.	270,000	-16.4	-21.7	270,000	---	---	---	---	---	---
D. C.	1,335,000	+56.5	+96.0	1,335,000	---	---	---	---	---	---
Fla. 3/	2,580,000	+4.2	+30.0	---	---	2,017,000	22,800	320,000	221,000	---
Ga.	3,730,000	-56.8	-26.1	3,730,000	---	---	---	---	---	---
Guam	4,900	-66.2	+157.9	4,800	---	---	---	---	---	100
Hawaii	931,000	-35.5	+17.6	799,000	---	---	---	---	---	132,000
Idaho	661,000	-11.6	+116.7	661,000	---	---	---	---	---	---
Ill.	19,276,000	+45.2	+37.4	17,590,000	---	---	---	---	---	1,686,000
Ind.	3,720,000	+5.1	+32.8	---	697,000	1,524,000	94,700	750,000	654,000	---
Iowa	2,815,000	+48.3	(4/)	2,815,000	---	---	---	---	---	---
Kans.	5,205,000	+285.8	+223.9	5,205,000	---	---	---	---	---	---
Ky.	7,207,000	+154.8	+71.7	7,207,000	---	---	---	---	---	---
La.	4,193,000	-28.2	+14.0	4,119,000	---	---	---	---	---	73,700
Maine	613,000	-39.1	-15.4	535,000	---	---	---	---	---	77,800
Md.	6,249,000	-49.4	+30.6	6,249,000	---	---	---	---	---	---
Mass.	21,252,000	+4.0	+10.6	20,472,000	---	---	---	---	---	780,000
Mich.	15,948,000	-5.9	+.3	15,793,000	---	---	---	---	---	155,000
Minn.	9,102,000	+3.1	+14.9	8,779,000	---	---	---	---	---	323,000
Miss.	505,000	+2.4	+17.2	---	---	429,000	5,400	71,500	---	---
Mo.	2,556,000	-68.8	-31.3	2,556,000	---	---	---	---	---	---
Mont.	911,000	-16.7	+6.9	637,000	---	---	---	---	---	274,000
Nebr.	1,274,000	+48.3	-23.8	1,274,000	---	---	---	---	---	---
Nev.	517,000	-24.0	+12.6	517,000	---	---	---	---	---	---
N. H.	357,000	-31.7	-3.3	357,000	---	---	---	---	---	---
N. J.	5,400,000	-.8	+24.0	---	5/ 3,398,000	173,000	15,100	462,000	1,003,000	349,000
N. Mex.	338,000	-79.5	-75.6	337,000	---	---	---	---	---	380
N. Y.	93,447,000	+1.7	+2.4	93,447,000	---	---	---	---	---	---
N. C. 3/	2,293,000	-2.2	+40.1	---	220,000	306,000	31,100	1,027,000	610,000	99,000
N. Dak.	1,005,000	+6.6	+36.2	998,000	---	---	---	---	---	6,900
Ohio	9,482,000	-10.5	-1.4	7,992,000	---	---	---	---	---	1,490,000
Okla.	6,407,000	-1.8	+7.5	6,407,000	---	---	---	---	---	---
Oreg.	1,170,000	-18.0	-27.1	1,084,000	---	---	---	---	---	86,100
Pa.	33,934,000	+541.5	+102.0	33,934,000	---	---	---	---	---	---
P. R. 6/	4,255,000	---	---	4,255,000	---	---	---	---	---	---
R. I.	1,380,000	-62.2	-37.0	1,207,000	---	---	---	---	---	173,000
S. C.	1,985,000	-46.0	+109.4	1,985,000	---	---	---	---	---	---
S. Dak.	554,000	-23.4	-24.2	482,000	---	---	---	---	---	71,700
Tenn.	1,546,000	-23.3	+4.0	---	6/ 170,000	1,248,000	1,800	42,500	83,600	---
Tex.	13,406,000	-22.1	+6.6	13,406,000	---	---	---	---	---	---
Utah	975,000	-10.4	+9.2	974,000	---	---	---	---	---	810
Vt.	1,018,000	+69.7	+49.3	1,018,000	---	---	---	---	---	---
V. I. 6/	65,500	---	---	65,500	---	---	---	---	---	---
Va.	129,000	-93.1	-85.7	129,000	---	---	---	---	---	---
Wash.	9,612,000	+93.1	+119.1	9,612,000	---	---	---	---	---	---
W. Va.	965,000	-11.1	-2.4	915,000	---	---	---	---	---	50,000
Wis.	11,880,000	-2.3	+21.1	11,627,000	---	---	---	---	---	253,000
Wyo.	149,000	-1.3	+10.4	96,200	---	---	---	---	---	53,000

1/ Amounts represent primarily bills paid during the month and therefore are subject to fluctuations unrelated to provisions of medical services. All data subject to revision.
2/ Data incomplete for general assistance. Some States do not report these data and for some the data represent only partial reporting.
3/ Except for aid to families with dependent children and general assistance, data represent payments for recipients of the specified types of assistance under program for aid to the aged, blind, or disabled, or for such aid and medical assistance for the aged.
4/ Increase of less than 0.05 percent.
5/ Excludes small amount of money payments not subject to Federal participation.
6/ Data for July not reported; data represent amounts reported for a previous month.

Table 13. Amount of medical vendor payments for public assistance programs under the Social Security Act, by form of payment and State, July 1969[1]

State	Total	Form of medical vendor payments	
		Payments to vendors directly or through fiscal agent	Premium or per capita payments 2/
Total	$387,629,000	$369,325,000	$18,301,000
Title XIX States	367,337,000	352,616,000	14,720,000
Other States	20,292,000	16,709,000	3,581,000
Title XIX States			
Calif.	63,886,000	62,789,000	1,079,000
Colo.	3,497,000	3,184,000	313,000
Conn.	9,078,000	9,001,000	77,800
Del.	270,000	262,000	7,900
D. C.	1,335,000	1,335,000	---
Ga.	3,730,000	3,316,000	414,000
Guam	4,800	4,800	---
Hawaii	799,000	799,000	---
Idaho	661,000	640,000	21,100
Ill.	17,590,000	17,425,000	165,000
Iowa	2,815,000	2,720,000	95,000
Kans.	5,205,000	5,111,000	94,000
Ky.	7,207,000	6,948,000	259,000
La.	4,119,000	4,119,000	---
Maine	535,000	479,000	56,200
Md.	6,249,000	6,249,000	---
Mass.	20,472,000	20,471,000	1,500
Mich.	15,793,000	15,665,000	128,000
Minn.	8,779,000	8,684,000	95,100
Mo.	2,556,000	2,174,000	382,000
Mont.	637,000	622,000	14,900
Nebr.	1,274,000	1,274,000	---
Nev.	517,000	517,000	---
N. H.	357,000	339,000	17,000
N. Mex.	337,000	337,000	---
N. Y.	93,447,000	92,952,000	494,000
N. Dak.	998,000	943,000	2/ 54,900
Ohio	7,992,000	7,712,000	280,000
Okla.	6,407,000	1,449,000	2/ 4,958,000
Oreg.	1,084,000	1,052,000	2/ 32,500
Pa.	33,934,000	33,558,000	376,000
P. R. 3/	4,255,000	4,255,000	---
R. I.	1,207,000	1,192,000	15,300
S. C.	1,985,000	1,890,000	94,700
S. Dak.	482,000	463,000	19,000
Tex.	13,406,000	8,475,000	2/ 4,931,000
Utah	974,000	956,000	18,000
Vt.	1,018,000	1,001,000	17,400
V. I. 3/	65,500	65,500	---
Va.	129,000	129,000	---
Wash.	9,612,000	9,456,000	2/ 156,000
W. Va.	915,000	915,000	---
Wis.	11,627,000	11,591,000	35,100
Wyo.	96,200	96,200	---
Other States			
Ala.	1,890,000	1,890,000	---
Alaska	109,000	109,000	---
Ariz.	199,000	156,000	43,300
Ark.	2,498,000	2,253,000	244,000
Fla.	2,580,000	2,198,000	382,000
Ind.	3,720,000	3,423,000	2/ 296,000
Miss.	505,000	505,000	---
N. J.	5,052,000	4,981,000	70,600
N. C.	2,194,000	1,022,000	2/ 1,171,000
Tenn.	1,546,000	172,000	2/ 1,374,000

1/ All data subject to revision.

2/ Entries represent premium payments into the Social Security Administration system for Supplementary Medical Insurance except for premium payments into an agency pooled fund by North Carolina-$1,171,000; Oklahoma-$4,662,000; Tennessee-$1,374,000; and premium payments to health-insuring agencies by Indiana-$220,000; North Dakota-$35,300; Oregon-$32,500; Texas-$4,018,000; and Washington-$10,800.

3/ Data for July not reported; data represent amount reported for a previous month.

--- Increase or less than 0.05 percent.
n.a. Excludes small amount of money payments not subject to Federal participation.
p Data for July not reported; data represent amounts reported for a previous month.

Table 14. General assistance: Recipients of money payments and amount of payments for selected cities, July 1969

[Excludes vendor payments for institutional services in intermediate care facilities and for medical care and cases receiving only such payments]

City	Number of--		Payment to recipients			Percentage change from			
				Average per--		June 1969 in--		July 1968 in--	
	Cases	Recipients	Total amount	Case	Recipient	Number of recipients	Amount	Number of recipients	Amount
Total, 15 cities 1/.....	169,000	315,000	$18,229,000	$107.80	$57.90	+1.1	+3.1	+7.6	-0.8
Baltimore.....	4,900	5,700	419,000	84.65	73.75	+4.5	+.5	-12.8	-10.7
Boston.....	6,600	9,200	731,000	110.85	79.75	+6.3	+7.7	+31.3	+41.2
Buffalo 2/.....	4,200	6,300	460,000	109.75	72.55	-3.0	-10.4	+2.0	+5.1
Chicago.....	(1/)	(1/)	(1/)	---	---	---	---	---	---
Cincinnati 2/ 3/.....	4,500	14,100	338,000	75.70	23.95	+10.3	+8.1	-18.6	-17.5
Cleveland 2/ 3/.....	10,500	29,000	968,000	91.85	33.40	+25.6	+20.3	+56.0	+47.4
Detroit.....	(1/)	(1/)	(1/)	---	---	---	---	---	---
District of Columbia.....	1,500	1,600	136,000	90.60	83.50	+2.4	+4.6	+56.7	+65.8
Los Angeles 2/.....	20,100	35,700	1,282,000	63.85	35.90	-8.6	-3.9	+4.9	+8.2
Milwaukee.....	4,200	9,600	365,000	85.95	38.10	+1.2	-5.8	+36.8	-35.1
Minneapolis.....	1,600	3,300	136,000	83.50	40.70	+12.4	+10.6	-15.8	-12.1
New Orleans.....	1,300	1,400	71,600	54.80	51.45	+.2	+.7	+21.7	+23.8
New York.....	74,100	148,000	9,364,000	126.30	63.10	-1.5	+2.5	-3.9	-20.2
Philadelphia.....	16,900	25,600	2,184,000	129.60	85.30	+2.3	+8.7	+58.9	+137.9
Pittsburgh.....	10,700	14,000	1,083,000	101.60	77.50	+3.7	+3.0	+46.6	+67.5
Rochester.....	1,100	2,800	122,000	115.35	44.05	-1.7	-4.0	+20.4	+40.3
St. Louis.....	(1/)	(1/)	(1/)	---	---	---	---	---	---
San Francisco.....	6,900	8,100	569,000	82.65	70.35	-3.0	-2.4	+10.8	+26.1

1/ Data not reported for Chicago, Detroit, and St. Louis. Percentage changes based on comparable data.
2/ Data for county in which city is located.
3/ Includes supplementation of categorical cases; not included in State data.

Table 15. Aid to families with dependent children: Assessments completed and referrals to manpower agencies by welfare agencies, and enrollments by manpower agencies under Work Incentive Program, by State, cumulative through July 1969[1]

State	Assessments completed			Referrals		Cumulative enrollments		Training spaces approved for fiscal year 1970	Individuals enrolled at end of period	
	Total	Appropriate for referral		Number	Percent of appropriate for referrals	Number	Percent of referrals		Number	Percent of training spaces
		Number	Percent of assessments completed							
Total	1,071,606	209,938	19.6	154,078	73.4	86,200	56.0	113,113	67,408	59.6
Ala	6,614	1,562	23.6	1,433	91.7	849	59.2	800	642	80.3
Alaska	633	327	51.7	327	100.0	342	2/ 104.6	560	227	40.5
Ariz	10,256	3,551	34.6	1,398	39.2	1,318	94.7	2,880	938	32.6
Ark	66	28	42.4	18	64.3	5	27.8	950	5	.5
Calif	194,031	68,513	35.3	61,268	89.4	27,085	44.3	12,000	19,958	3/ 166.3
Colo	7,938	3,025	38.1	1,265	41.8	1,145	90.8	3,600	793	22.0
Conn	13,246	2,430	18.3	2,430	100.0	1,507	62.0	1,200	1,017	84.8
Del	250	55	22.0	55	100.0	20	36.4	310	20	6.5
D. C	1,843	1,138	61.7	1,138	100.0	1,377	4/ 121.0	1,200	1,086	90.5
Fla	(2/)	(2/)	---	(2/)	---	(2/)	---	2,680	(2/)	---
Ga	182	66	36.3	66	100.0	53	80.3	1,440	52	3.6
Guam	(6/)	(6/)	---	(6/)	---	59	---	140	47	33.6
Hawaii	35,970	2,571	7.1	1,583	61.6	295	18.6	300	231	77.0
Idaho	95	49	51.6	44	89.8	79	7/ 179.5	430	77	16.0
Ill	9,018	5,773	64.0	5,174	89.6	1,849	35.7	5,000	1,544	30.9
Ind	(2/)	(2/)	---	(2/)	---	(2/)	---	1,000	(5/)	---
Iowa	510	344	67.5	99	28.8	484	2/ 488.9	700	453	64.7
Kans	3,065	1,166	38.0	956	82.0	787	82.1	700	552	78.9
Ky	15,582	7,092	45.5	2,096	29.0	1,695	81.3	2,000	1,507	75.4
La	7,077	1,276	18.0	693	54.3	614	88.6	2,200	519	23.6
Maine	1,800	509	28.3	327	64.2	179	54.7	400	120	30.0
Md	25,089	3,394	13.5	3,165	93.3	1,807	57.1	5,100	1,607	31.5
Mass. 8/	9,130	4,273	46.8	5,354	3/ 125.3	2,988	55.8	3,000	2,293	76.4
Mich	53,305	8,014	15.0	8,014	100.0	4,355	54.3	5,000	3,726	74.5
Minn	442	442	100.0	442	100.0	420	95.0	1,200	405	33.8
Miss	4,693	2,370	50.4	241	10.2	221	91.7	1,000	171	17.1
Mo	3,734	1,779	37.0	1,423	9/ 102.2	1,266	89.0	1,200	936	52.0
Mont	1,236	604	48.9	412	68.2	351	85.2	710	362	34.1
Nebr	(2/)	(2/)	---	(2/)	---	(2/)	---	430	(5/)	---
Nev	(2/)	(2/)	---	(2/)	---	(2/)	---	0	(5/)	---
N. H	(5/)	(5/)	---	(5/)	---	(5/)	---	0	(5/)	---
N. J	7,593	6,336	83.4	6,202	97.9	3,432	55.3	2,600	2,899	3/ 111.1
N. Mex	0	0	---	10/ 0	---	10/ 82	---	450	58	12.9
N. Y	548,295	37,823	6.9	10,035	26.5	5,936	59.2	12,000	5,412	45.1
N. C	(2/)	(2/)	---	(2/)	---	(2/)	---	1,600	(5/)	---
N. Dak	557	395	70.9	388	98.2	276	71.1	440	200	45.5
Ohio	10,351	7,696	62.0	4,761	62.2	3,032	63.7	4,600	2,376	51.7
Okla	1,270	378	29.8	0	---	(5/)	---	450	(5/)	---
Oreg	399	369	92.5	369	100.0	221	59.9	1,350	218	16.1
Pr	22,655	7,059	31.2	6,730	95.3	4,795	71.2	5,600	4,072	72.7
R. I	17,583	5,223	29.7	4,345	83.2	2,426	55.8	3,500	2,003	57.2
S. C	2,179	1,123	51.5	1,119	99.6	638	57.0	600	479	79.8
S. Dak	253	28	11.1	28	100.0	(5/)	---	300	(5/)	---
Tenn	1,237	739	59.7	219	29.6	233	7/ 108.7	400	209	52.3
Tex	8,785	1,930	21.5	1,347	71.3	1,156	85.8	1,200	944	73.7
Utah	0	0	---	0	---	(5/)	---	1,600	(5/)	---
Vt	1,294	1,165	90.0	1,165	100.0	1,153	99.0	2,950	813	27.6
V. I	825	504	61.1	369	73.2	271	73.4	200	186	93.0
Va	(6/)	(6/)	---	(6/)	---	(6/)	---	43	(6/)	---
Wash	1,288	712	55.3	670	94.1	558	83.4	800	521	65.1
Wash	26,598	9,440	35.5	8,690	92.1	3,301	38.0	4,200	1,906	47.3
W. Va	6,969	6,718	96.4	6,383	95.0	5,965	93.5	7,400	4,471	60.4
Wis	5,182	2,247	43.4	1,715	76.3	1,461	85.1	1,860	1,314	70.6
Wyo	678	182	26.8	168	92.3	129	76.8	100	88	88.0

1/ WIN Program operations, initiated in individual States in various months beginning with July 1968. Source of data: Assessments and referrals - Department of Health, Education, and Welfare; enrollments and training spaces - Department of Labor.
2/ Excess of enrollments over referrals under investigation.
3/ Enrollments exceed approved training spaces because of trainees in holding status, i.e., awaiting assignments or reassignment to training activity.
4/ Enrollments exceed referrals because enrollees include persons in Temporary Assistance Program for Families of Unemployed Parents who are not referred through the regular referral process.
5/ WIN Program operations not yet initiated.
6/ Not reported.
7/ Enrollments exceed referrals because some trainees under Title V of the Economic Opportunity Act were assigned directly to WIN projects without reassessment.
8/ Data for referrals beginning October 1968; data for assessments beginning December 1968.
9/ Excess of referrals over number found appropriate for referral under investigation.
10/ Some AFDC recipients who were trainees under Title V of the Economic Opportunity Act have been assigned directly to WIN projects without reassessment.

Table 16. Old-age, survivors, disability, and health insurance, summary benefit data, July 1969

CASH BENEFITS AWARDED AND IN CURRENT-PAYMENT STATUS

Type of beneficiary	Benefit awards		Benefits in current-payment status			Amount of benefits paid 1/ (in thousands)
	Number	Average amount	Number	Average amount	Monthly rate (in thousands)	
Total monthly beneficiaries	291,535	---	24,921,490	---	$2,114,638	$2,212,638
Retired workers and dependents	141,120	---	15,795,843	---	1,418,306	1,456,228
Retired workers	100,633	$106.72	12,642,265	$99.84	1,262,177	1,287,388
Wives and husbands	26,472	50.26	2,637,359	51.65	136,210	147,376
Children 2/	14,015	41.87	516,219	38.59	19,918	21,464
Disabled workers and dependents	64,660	---	2,405,557	---	188,900	214,805
Disabled workers	28,791	118.40	1,349,509	112.28	151,527	170,243
Wives and husbands	8,388	39.33	255,240	38.04	9,710	11,588
Children 2/	27,481	34.15	800,808	34.54	27,663	32,974
Survivors of deceased workers	82,024	---	6,089,372	---	482,704	516,385
Widowed mothers	8,183	76.93	500,100	74.87	37,442	40,571
Children 2/	43,947	69.87	2,529,129	70.85	179,193	192,744
Widows and widowers 3/	29,719	90.29	3,029,462	86.93	263,350	280,099
Parents	175	101.04	30,681	88.61	2,719	2,971
Special age-72 beneficiaries 4/	3,371	---	630,718	---	24,728	25,220
Primary	3,618	---	613,423	39.75	24,383	24,866
Wives	113	---	17,295	19.96	345	354
Lump-sum death payments 5/	94,316	234.58	---	---	---	21,284

1/ Exceeds monthly rate of benefits in current-payment status because of the inclusion in initial payments of amounts payable for prior months. Distribution by type of monthly benefit estimated.

2/ Includes disabled persons aged 18 and over whose disability began before age 18.

3/ Includes actuarially reduced benefits for widows and divorced wives aged 60-61; a total of 130,380 such beneficiaries were in current-payment status. Also includes disabled widows and widowers aged 50-61; a total of 33,285 such persons were in current-payment status.

4/ Represents benefits authorized by Public Law 89-368(1966) for certain persons aged 72 and over who are not insured under the regular or transitional insured status provisions of the Social Security Act.

5/ Number of lump-sum payments shown were paid on the accounts of 90,731 deceased workers; the average amount represents average per deceased worker.

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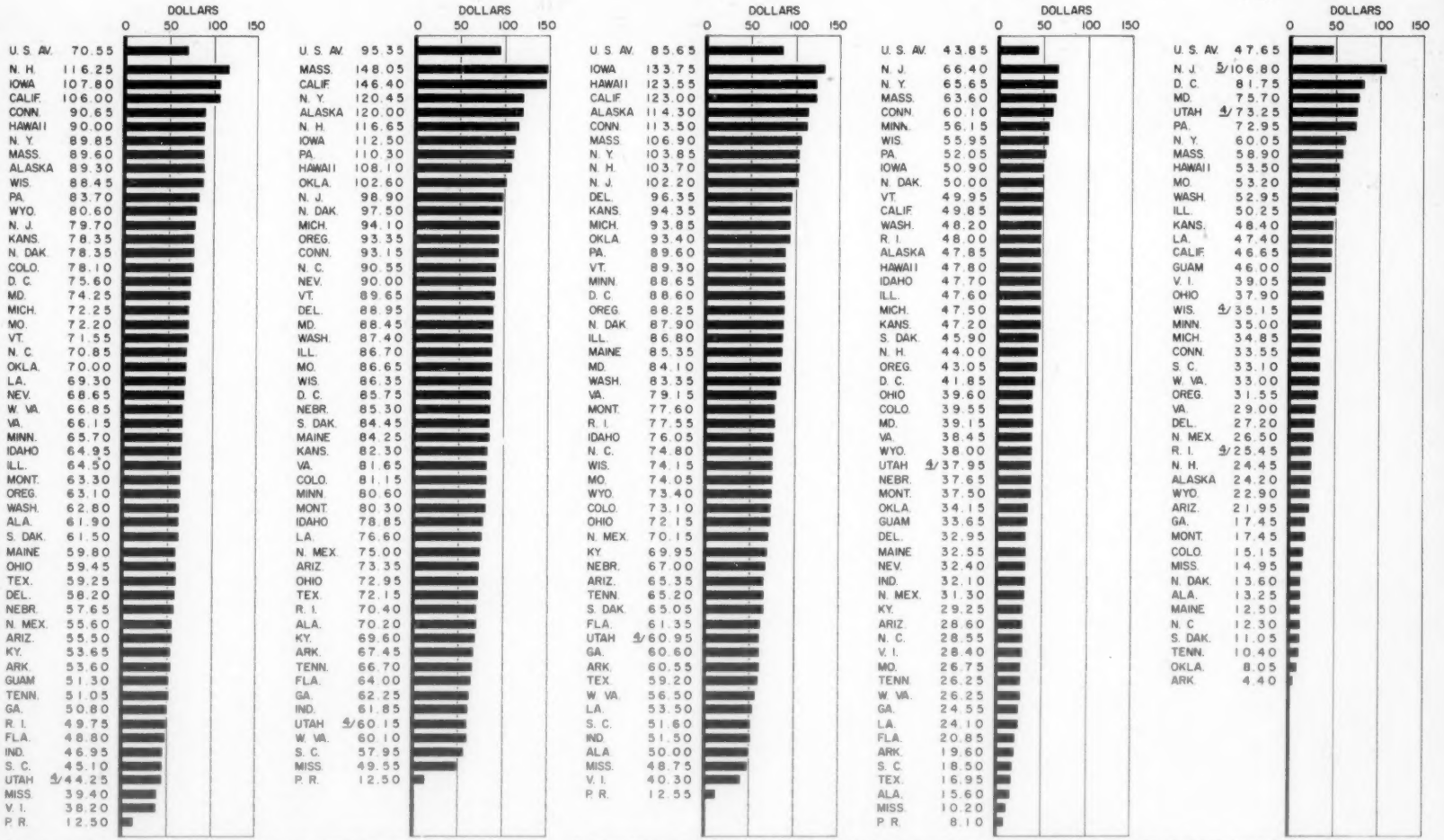

1/ NOT COMPUTED FOR GUAM, VIRGIN ISLANDS, AND WYOMING; FEWER THAN 50 RECIPIENTS. IOWA, KENTUCKY, NEBRASKA, NEVADA, PUERTO RICO, TEXAS, AND VERMONT; DATA NOT AVAILABLE.

2/ NO PROGRAM FOR NEVADA. NOT COMPUTED FOR GUAM; FEWER THAN 50 RECIPIENTS.

3/ NOT COMPUTED FOR FLORIDA, IDAHO, INDIANA, MEDICAL CARE, HOSPITALIZATION, AND BURIAL ONLY, AND TOTAL PAYMENTS FOR THESE SERVICES.

4/ REPRESENTS DATA FOR MAY; JUNE DATA NOT REPORTED.

5/ BASED ON DATA INCLUDING AN UNKNOWN NUMBER OF CASES RECEIVING

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